Somerset Care Limited

Inver 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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 2 and 6 August 2018 and was unannounced.

Inver House is a 'care home' owned by Somerset Care Limited. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. The inspection team looked at both during this visit.

Inver House is registered to provide personal care and accommodation for up to 50 people. At the time of the inspection, there were 44 people living at the home. The provider divided the home into three units. One unit provided care and support to older people and the other two units provided care and support to people who were living with dementia. Two lifts are available to assist people to access the upper floors. The home has several dining areas and lounges, there was also a hair salon and communal IT facilities are available for people to use if they wished. The grounds were well-maintained and accessible to people living in the home.

At our last inspection, we rated the service as Good in all key question areas of Safe, Effective, Caring, Responsive and Well-led. At this inspection we found the information supported the rating of Good with the key question of Responsive which had improved to a rating of Outstanding.

At the time of this inspection, there was a manager in place who had taken over the overall running of the service in the absence of the registered manager. The manager had commenced the registration process with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People felt safe living at Inver House. People were protected from the risks of abuse and staff were trained in recognising and reporting safeguarding concerns. Safeguarding investigations were thorough and identified learning to help prevent a reoccurrence.

Individual and environmental risks to people were managed effectively. Risk assessments identified risks to people and provided clear guidance to staff on how risks should be managed and mitigated.

There were enough staff to meet people's needs and staff were able to support people in a relaxed and unhurried way. Appropriate recruitment procedures were in place to help ensure only suitable staff were employed.

People received their medicines safely and as prescribed. Appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

People were protected from the risk of infection. Staff had received infection control training. The home was visibly clean and well maintained and infection control audits were completed regularly.

People's needs were met by staff who were competent, trained and supported appropriately in their role. Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People had access to health professionals and other specialists if they needed them. Staff worked in partnership with healthcare professionals to support people at the end of their lives to have a comfortable, dignified and pain-free death.

Procedures were in place to help ensure that people received consistent support when they moved between services.

People were provided with enough to eat and drink and mealtimes were a relaxed and sociable experience for people. Where people had specific dietary requirements, these were known by staff and catered for.

Staff treated people with kindness, respect, and compassion. People were actively involved in making decisions about their care. Staff respected people's privacy and dignity and encouraged the independence of people living at the home.

People's cultural and diversity needs were explored to help ensure that people could be provided with effective, person centred care and support.

The management team and staff were proactive in using national guidance to better understand people's individual needs to help ensure that effective person-centred care could be provided.

The management team and staff went the extra mile to help ensure that people were supported to maintain their interests.

The service had an innovative approach to using technology.

There were well established within the local community. The management team and staff were actively involved is alleviating loneliness for the people living at Inver House and the people within the wider community.

Care and support was planned proactively and in partnership with the people, their families and multidisciplinary teams where appropriate.

People knew how to raise concerns, which were listened and positively responded to and were used to make further improvements.

There were robust quality auditing processes in place. The quality of the service was monitored and appropriate actions were taken when required.

The provider used feedback to improve the quality of care. There was a clear vision to deliver person centred care, which achieved good outcomes for people.

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 remains Good

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Outstanding ☆

The service has improved to Outstanding

The service was highly responsive to people's changing needs.

The management team were proactive in using national guidance to better understand people's individual needs to help ensure that effective person-centred care could be provided.

Staff went the extra mile to help ensure that people were supported to maintain their interests and there was an innovative approach to using technology.

Inver House was well established within the local community. The staff were actively involved is alleviating loneliness for the people living at Inver House and those in the wider community.

Care and support was planned proactively and in partnership with the people, their families and multidisciplinary teams where appropriate.

People knew how to raise concerns, which were listened and positively responded to and were used to make further improvements.

Is the service well-led?

Good

The service remains Good

Inver 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 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 2 and 6 August 2018 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before 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 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.

During the inspection we spoke with 11 people living at the home and six family members. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager, the deputy manager, two members of the catering team, two activities coordinators and five care staff. We also received feedback from two social care professionals and one healthcare professional who had contact with the service.

We looked at five people's care plans in detail and reviewed specific associated records for seven people. We also looked at staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in December 2015 when it was rated as 'Good'.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe. One person told us, "Oh yes, I feel safe. There's always someone on duty, day and night." Another person said, "I feel safe, there are so many people around." A relative told us they felt their relative was safe "because of the security, no one can get in."

The provider had appropriate policies in place to protect people from abuse. Staff were required to complete safeguarding training as part of their induction and received annual updates. Staff were knowledgeable in recognising signs of potential abuse, knew how to raise concerns and how to apply the provider's safeguarding policy. One staff member told us, "If I had any concerns I would report it to the senior on shift; I would go to the manager, head office or contact the safeguarding team or you [CQC] if I needed to." All staff were confident the manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. Records confirmed appropriate action had been taken when a safeguarding concern had been identified.

Individual risks to people were managed effectively. Appropriate and effective risk assessments had been completed where required which identified possible risks to people and actions staff needed to take to reduce and mitigate risks. For example, where people were at risk of developing pressure sores the risk assessments and care plans included clear information for staff in relation to equipment the person required and how often the person should be supported or encouraged to change their position. Additionally, monitoring charts had been put in place which demonstrated that people's positions had been changed in accordance with the guidance in their risk assessment. For people who behaved in a way that might present a risk to the person or others, the risk assessments in place highlighted the behaviours, possible triggers and actions staff should take to help them to mitigate any escalation of behaviours. Other risks were monitored and managed and risk assessments in place included moving and positioning and medicines management.

There was sufficient staff available to meet people's needs. Care staff were augmented by other ancillary staff, such as housekeeping, maintenance and catering. This meant they could focus on providing care and engaging with the people they supported. There was a duty roster system, which detailed the planned cover for the home. Staff absence were covered by existing staff working additional hours. The manager confirmed that although cover is provided by existing staff, they would source additional support from agency staff if needed.

The provider had a safe and effective recruitment process in place to help ensure that staff recruited were suitable to work with the people they supported. Relevant checks were carried out before a new member of staff started working at the service. These included the completion of Disclosure and Barring Service (DBS) checks, which will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff files included application forms, records of interview and references.

People we spoke with told us staff supported them to take their medicines. One person told us, "They [staff] are very good with medication." Another person said, "I always get my medicine when I am supposed to."

The provider had robust medicine management procedures in place. All staff who administered medicines had received appropriate training yearly and had their competency assessed by a member of the management team three monthly, to ensure their practice remained safe. The manager carried out a weekly medicine audit and Medicine Administration Records (MARs) were checked daily by a senior staff member to ensure that people had received their medicines as prescribed. We checked the MARs for nine people and these all showed that people had received their medicine as prescribed. Appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

Safe systems were in place for people who had been prescribed topical creams. All topical creams viewed were in date and labelled in accordance with best practice. This meant staff were aware of when the topical cream would no longer be safe to use.

Some people needed 'as required' (PRN) medicines; for example, for pain relief or anxiety. People told us that if they were experiencing pain, staff would provide them with pain relief. Staff had information about the PRN medicine for people and there were individual guidelines as to when 'as required' medicines should be given, how the effects of the medicine should be monitored and actions that should be taken if the required effect was not achieved. This helped to ensure that these medicines were given to people appropriately.

People were protected from the risk of infection. Staff had received infection control training and had access to personal protective equipment such as disposable aprons and gloves. The home was visibly clean and communal areas, bedrooms and bathrooms smelt fresh and were well maintained. Infection control audits were completed regularly by a member of the management team. People's comments included, "All they do is clean", "My room is kept very clean and tidy" and, "They [staff] always wear their gloves when helping me." A family member described the cleanliness of the home as "Brilliant."

Environmental risks had been considered. For example, non-slip flooring was in place, Personal protective equipment (PPE); such as gloves and aprons were not accessible to people within the dementia units due to risk of choking and all doors and cupboards which contained at risk items such as medicine and Control of Substances Hazardous to Health (COSHH) were not accessible to people. Equipment such as hoists and lifts were serviced and checked as per equipment guidance. Environmental risk assessments and health and safety audits were completed monthly and general audit checks of the building were done weekly by the management team. Additionally, the operations manager of the company visited the service on a monthly basis to review the completed audits to ensure that actions had been taken where required. The audits we looked at were robust and showed a clear action trail which demonstrated any issues that had been identified were acted upon immediately.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was checked regularly. Personal evacuation and escape plans had been completed for each person, detailing action needed to support people to evacuate the building in the event of an emergency.

Good

Is the service effective?

Our findings

People, their families and health and social care professionals told us effective care was provided by experienced and competent staff. A family member said, "It's amazing, the level of care [name of relative] gets." Another family member told us, "We're quite satisfied and she's very happy." People's comments included, "I like it. I'm very happy here", "It's the best place for me at the moment", "It's very good" and "I'm well looked after."

Staff followed the principles of 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. We found assessments of people's capacity had been completed, where needed. Records showed that where people lacked capacity, decisions made on their behalf were completed in their best interests and people who knew the person well had been involved in making these decisions, such as professionals and relatives.

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. At the time of the inspection six people living at the home were subject to a DoLS and staff were aware of the conditions that were attached to these.

Staff understood the importance of obtaining consent before assisting people with aspects of their care. Throughout the inspection, we saw that staff gained verbal consent from people before providing them with care and support. Staff used simple questions and gave people time to respond. A person told us, "They [staff] do ask me first, it's nice." A second person said, "I ask them, so they don't need any permission because I've given it." Staff were aware of people's rights to refuse care and were able to explain the action they would take if care was declined.

People were supported by staff who had received a robust induction into their role, which enabled them to meet the needs of the people they were supporting. All new staff were provided with a 'Welcome Pack' which outlined the expectations of the induction. Staff completed mandatory training and 'shadow shifts' with experienced staff before being allowed to work unsupervised. A mentor was appointed to support new staff through their induction period. Mentors observed new staff members care practice, including their adherence to infection control procedures, answering call bells and delivering personal care to identify further training or development needs and provided feedback to the management team.

Care was delivered by staff with the skills and knowledge to provide effective support. Comments from people and relatives included, "They're exceptional" and "I think they are well trained and know what they are doing; most of the time. There seems to be lots of new staff at the moment, but they've picked up things

pretty quickly." Staff confirmed they were able to access the training they needed. An electronic record of staff training was used to help the manager easily identify and update training needs in a timely way.

Staff were appropriately supported in their role. Staff confirmed that they received regular one-to-one sessions of supervision with a member of the management team and a yearly appraisal with the manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. The manager told us that in addition to the one-to-one supervision sessions, staff were also regularly observed by the management team and provided with feedback in relation to these observations.

People were provided with enough to eat and drink and people told us they enjoyed the food. Comments included, "It's very good", "It's very nice. They have a good chef and good staff", "It used to be quite good, but it's deteriorated recently" and "I'm drinking all day. I have about seven cups of tea all day and I have water. I have a flask and I take it down and they put it in the fridge, so it's cold."

Mealtimes were a relaxing and sociable experience for people. People were given the opportunity to serve themselves vegetables, although staff provided assistance if needed. The desserts were shown to people on a trolley and they were able to select combinations of food. Each table was provided with a pot of tea at the end of the meal. This approach encouraged independence and people to interact socially. Requests for assistance were responded to promptly and patiently.

People were offered choices about what they wished to eat and drink. If people did not want what was offered from the main menu, alternatives were provided. People's specific dietary requirements were known by staff and catered for. For example, one person was unable to eat red meat, another could not eat certain foods due to a prescribed medicine and others had diabetes. Kitchen staff were able to explain how they met these people's dietary requirements in line with their care plans.

People's weights were monitored and appropriate action was taken if people were identified as being at risk of malnutrition, such as making a referral to a dietitian. Similarly, if people were observed to have difficulty swallowing, a swallowing assessment was sought with a speech and language therapist. People at risk of choking or aspiration were provided with thickened fluids and mashed or pureed foods in accordance with their safe swallowing plan.

People were supported to access appropriate healthcare services when required. The manager told us that they had a good relationship with the local GP who visited the home weekly, to discuss the health needs of people living at the home. People confirmed that they were supported with their health needs by the staff when required. A person said, "There's a weekly visit from the doctor. If you needed to see him urgently, they [staff] would arrange it." Another person told us, "When I want to see the doctor, I can." People's care files showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs.

Information relating to people's health needs and how these should be managed was clearly documented within people's care plans and some contained additional information to aid staff understanding about a certain condition and how this affected the person's abilities. Staff knew people's health needs well and were able to describe the action they would take in a
medical emergency, such as if they suspected a person had had a stroke, or if a person had suffered a head injury.

There were clear procedures in place to help ensure that people received consistent support when they

moved between services. The manager told us that new services were provided with an up to date information form about the person and if required, the person would be accompanied by a member of staff during the transfer.

The manager and staff made appropriate use of technology to support people. The service used a computerised system to document each person's care plan and this was accessible to staff. People were provided with equipment to help keep them safe, including pressure mats to alert staff when people moved to unsafe positions and pressure relieving mattresses. There was electronic call bell system in place which allowed people to call for assistance when needed and the management team used this to identify staff responses where people had requested support via their call bell.

The environment was well maintained and appropriate for the people who lived there with passenger lifts to all floors. The home was decorated to support people living with dementia or poor vision and included picture signs on toilet, bathroom and bedroom doors and hand rails of contrasting colours to the walls. Additionally, some bedroom doors were painted different colours to allow people to identify their own bedrooms more easily. Throughout the home, there were various homely items designed to assist with memories or provide interest and stimulation for people living with dementia. There were also notice boards and displays for people to view. These gave people the opportunity to reminisce about past events and provided them with information about the home and future activities. People's bedrooms had been decorated to their tastes, and contained some of their own furniture and important personal possessions. People had access to a variety of different communal areas in the home, which meant they could choose whether they spent time with others or alone. People had access to the gardens which were safe, fully enclosed and provided various seating options.

Good

Is the service caring?

Our findings

Staff showed care, compassion and respect towards the people living at Inver House. People, families and professionals spoke positively about the attitude and approach of staff. Comments from people included, "Staff are very caring", "It's difficult for them, they have so many people, but all of them are caring" and "They are pleasant and obliging." A family member said, "[Name of relative] sees them as his family. He has built up trust with them. He can have a joke and a laugh with them and goes to them for support." Another family member said, "The staff are genuinely caring, they want the best for [relative]."

There was a relaxed and calm atmosphere within the home and people, their families and staff described the home as having a 'family atmosphere.' Written feedback received from a visiting professional stated, 'I really love coming out to Inver House. The home has a really nice atmosphere and all the staff are kind and friendly.' People, family members and professionals confirmed that they would be happy to recommend the home to others.

Staff expressed a commitment to treating people according to their individual needs, wishes and preferences. An activities coordinator said, "We just want to make a difference to people's day, its lovely seeing them smile or that glint in their eyes." Another staff member said, "People need to feel needed and like they have a purpose." During the inspection, a person who lived with a cognitive impairment began to fold some cloths and put them neatly in a basket. They also assisted a member of staff to fold towels. The repetition of this familiar task seemed to soothe the person and the staff member thanked them for the help they had provided.

People were cared for with dignity and respect and all interactions we observed between people and staff were positive and supportive. We saw staff kneeling down to people's eye level to communicate with them. People were listened to by staff who gave them the time they needed to communicate their views and wishes. We heard good-natured interactions between people and staff, showing they knew people well. When people needed assistance to mobilise, staff provided support in a relaxed and calm way, while giving the person reassurance and encouragement. Staff emphasised the importance of ensuring people's privacy was respected and were able to describe steps they would take to maintain people's privacy when providing personal care.

The activities coordinator told us they explored people's cultural and diversity needs by talking to them, their families and by getting to know them and their backgrounds. This information was then documented within the person's care file. The activities coordinator added that if a person followed a particular faith they would research this by looking for information on the internet and speaking to followers of that faith, to ensure that people could be effectively supported. The management team had also recently attended Lesbian, Gay, Bisexual and Transgender (LGBT) training to help increase their knowledge and understanding in these areas.

Throughout the inspection, staff sought people's opinions and asked for their feedback. This was done informally and in a conversational manner. Staff listened carefully to what people said and responded

positively to people. People could make choices about the care and support they received. Where people had specific communication needs, these were recorded in their care plans and known by staff. Where people had a sight impairment, written information had been produced in large print to enable them to read it more easily. Photos and pictures were also used when required to support people with communication and enable them to make informed choices.

People were supported to retain their independence. A person told us, "I like to be independent and to do as much as I can for myself. If I need to ask, I know they'll help with no moans or groans." Another person said, "I like to do everything myself. I try to keep independent." In people's care plans we saw detailed information advising staff what people could do for themselves. For example, one person's care plan stated, 'I am able to drink and eat independently and can use all cutlery unaided.' Another read, 'I find it easier to eat using a 'lipped' plate.' This showed the person's wishes for their individual support needs and independence was respected.

Outstanding ☆

Is the service responsive?

Our findings

The service was highly responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals. Healthcare professionals confirmed they were contacted appropriately, in a timely way and that staff always followed any recommendations they made. Written feedback from a healthcare professional stated, 'I gave support and guidance last time I visited which the carers have implemented and this has improved the resident's wellbeing which is great to see.'

Additionally, the service followed national guidance from NHS England to ensure they were responsive to meeting the changing needs of people living with dementia. The manager told us that some staff had received dementia care mapping training. Dementia Care Mapping (DCM) is one way of implementing person-centred care and involves continuously observing the behaviour of people with dementia and the care they receive. Dementia Care Mappers record their observations to better understand the behaviours of people less able to communicate so that where highlighted patterns in behaviours can be identified and new approaches to care can be implemented.

Staff were kept up to date on people's changing needs through verbal handover meetings, which were held in between the day shifts. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

The service went the extra mile to help ensure that people were supported to maintain their interests and were provided with appropriate mental and physical stimulation through a range of varied activities. People were asked about their 'special wish', where they thought about what they would do if they could. People's responses were listened to and were possible, the activities coordinators made arrangements for people's 'special wish' to come true. For example, one person said that they really wanted to visit France but were unable to do this due to their needs. The staff at the home brought 'France' to the person and a French day was arranged, included dressing up, decorating the home in a French theme and eating French foods. Another person requested a visit to the local bus museum as they had previously worked on the buses and continued to have an interest in this. Staff arranged a visit for the person to the bus museum where they found their photo displayed on the wall of employees which made them feel very proud. A third person wanted to go to the beach for their 99th birthday and enjoy a '99' ice cream. This was facilitated and staff reported that they were keen to share this experience with their family. A written compliment stated, 'I am really grateful to the activities coordinators who take me out to the village on a regular basis; it means a lot to me.'

Activities were provided both in groups and individually. Activities included arts and crafts, reminiscence, quizzes, arm chair exercises, music, cooking, pampering sessions and trips out, both in groups or on a one-to-one basis. Minibus trips were arranged and there were regular visits from local singing groups, drama clubs and pre-school children.

The service had an innovative approach to using technology. A care technologist was employed by the

service who provided workshops for staff and people to introduce them to computer skills and the use of technology. These workshops covered topics such as Social Media, YouTube, Netflix/Catch up TV, Digital photography, Skype and the use of specialist computer applications to aid communication. These workshops helped people to increase their skills, promote their independence and help them to stay connected to families and friends. Virtual reality equipment was being used to aid reminiscence and learning from these projects is being shared across the Somerset care group.

Inver House is well established within the local community and has built relationships with sheltered accommodation and supported living complex's in the local area. Events were often held at the home including summer fayres, coffee mornings and awareness days. During the 'National Day for Tackling Loneliness', cakes were delivered to people who lived alone by staff and people living at Inver House. Following the inspection, the manager also notified us of their passion for alleviating loneliness and said that they recognise that some of the people living at the home may often feel lonely and struggle to make connections with people. Therefore, the staff organised 'Tea and Talk' time to address this. The deputy manager said that these sessions occurred up to three times a week and give people the opportunity to have tea with a staff member on a one to one basis or in small groups to share ideas, talk about their views and feelings and meet other people. On 'National Picnic Day' children from the local pre-school were invited to the home to have a picnic in the garden and play games with the people who lived at Inver House.

People told us they received personalised care and support that met their needs. People and family members felt that staff made an active effort to get to know them and understand their needs. Each person's care plan contained information about their specific needs and how they wished them to be met. People's care plans were clear, detailed, and person centred and enable staff to give appropriate care in a consistent way. For example, one person's care plan stated, 'I like to get up early; I like to sleep with my window and curtains closed; bedside lamp on and door slightly open.' Another said, 'I like small meals. My drinks need to be thickened with one scoop of (type of thickening agent) to 200 mls of fluids.' Where people required a hoist to help them mobilise, the information within the care plan advised staff on the type of hoist and hoist sling that was required. All the staff we spoke with told us that they found the care plans informative and demonstrated that they understood people's needs, likes and dislikes. Care plans were reviewed every three months or when the person's needs changed.

Staff kept records of the care and support they provided to people. We looked at a sample of the care records, which demonstrated that care was delivered in line with people's care plans and wishes. Additional records kept if required included 'repositioning charts' for people who needed support to reposition regularly and food and fluid monitoring charts for people who were nutritionally at risk. We viewed these records and saw they were completed clearly and accurately, which confirmed that people's needs had been met consistently.

Care and support was planned proactively and in partnership with people, their families and healthcare professionals where appropriate. A member of the management team completed assessments of the people before they moved to the home, to ensure their needs could be appropriately met. People and their family members told us they were involved in their care. A family member told us, "We're constantly involved; any change and there's a phone call." People had regular contact and were supported to see their family members. One family member told us, "I'm always made welcome." A second said, "We can visit whenever we want and we can get involved in the activities."

People told us they knew how to raise a complaint and felt happy that if they did so, they would be listened to. Information on how to complain was easily accessible to people and family members. A family member said, "I did recently [complain]; they [manager] took it seriously." A person told us, "I haven't needed to

complain, but I would if I needed to." The manager told us that they had received no formal complaints in the last 12 months, but did receive the occasional 'niggle' from people or their families. This had resulted in a 'complaints and niggles' form being produced for people to complete when a concern was raised. The manager showed us the 'complaints and niggles' file which demonstrated that all issues raised were discussed and appropriate action has been taken where required. The management team were clear about their responsibilities to investigate any complaints and were able to describe the process they would take when dealing with any issues or concerns.

At the time of the inspection no one living at Inver House was receiving end of life care. However, the manager was able to provide us with assurances that people would be supported to receive effective support to help ensure a comfortable, dignified and pain-free death. Staff members had received training in end of life care and we found that the end of life wishes and preferences for people had been recorded within people's care records. This helped to ensure that people's wishes were respected and acted upon.

Good

Is the service well-led?

Our findings

At this inspection, there was a manager in place who had taken over the overall running of the service in the absence of the registered manager. The manager had commenced the registration process with the Care Quality Commission (CQC). Although the registered manager was currently unavailable, there was still a clear management structure in place. This structure consisted of an operations manager, the manager, the deputy manager, a team of supervisors and shift leaders. Each had clear roles and responsibilities which were understood by all staff. Following the inspection, the provider told us that their continued good performance was a credit to the interim manager and a testament to the leadership and team working an Inver House.

Staff told us they felt supported and valued by the management of the service and other members of the staff team. Staff comments included, "We are a very good team", "I definitely feel supported and valued" and "I was never supposed to be here long term, but I just can't leave; I love it so much." The manager told us about initiatives put in place by the providers to ensure staff felt valued. These including long service awards and career progression opportunities.

The provider was engaged in running the service and their vision and values centred on providing care that promotes privacy, dignity and respect to people in a personalised way. The manager told us, "We want to improve people's quality of life; all people have a purpose and still have aspirations. Even if they give up hope, we don't." Staff were aware of the provider's vision and values and how this related to their work. Staff meetings provided the opportunity for the provider's operations manager and manager to engage with staff and reinforce the vision and values. The operations manager visited the home monthly to oversee the running of the service and the manager sent them a weekly report, which highlighted any issues that there had been or that needed to be addressed.

The management of the service had processes in place which sought people's views and used these to improve the quality of the service. Relatives and visitors told us they had expressed their views about the service through one to one feedback directly, surveys and individual reviews of their relative's care. People and relative's meetings were held monthly and these meetings provided people and their families with the opportunity to give feedback about the culture, quality and development of the service. From the minutes of the last meeting, we saw that discussions had taken place about future activities, the food choices and any concerns people had about the home. Any suggestions or concerns raised by people, families, staff and professionals were analysed by the management team who considered and acted on suggestions or concerns raised. There was a 'You Said We Did' feedback system in place where people could make comments and suggestions and these were displayed in the home with the action that had been taken. One person has commented, 'I'd like to see more outdoor activity for men, like a golf course' and the response from the provider was, 'we made a golf course.' People and their families said that they felt listened to by the management team and their views were considered. One person said, "I fill in a form every month (about my views)" and a family member told us, "They are always willing to listen and answer any worries and put things right."

The service worked with other health and social care professionals in line with people's specific needs. This also enabled staff to keep up to date with best practice, current guidance and legislation. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of professionals working together, such as GPs and community nurses. Medical reviews took place to ensure people's current and changing needs were being met.

There were processes in place to enable the management team to monitor accidents, adverse incidents or near misses. These helped to identify any themes or trends, allowing timely investigations, potential learning and continual improvements in safety. The manager kept up to date with best practice through training and reading relevant circulations / publications and updates provided by trade and regulatory bodies.

The service had a programme of audits and quality checks and these were shared out between the members of the management team and the maintenance person. Regular audits had been completed of the environment, medicines, care records, health and safety and infection control. Where concerns were identified action plans were produced and actions were taken within a timely manner.

Inver House had up to date and appropriate policies in place to aid with the running of the service. For example, there was a whistle-blowing policy in place which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The manager showed us examples of where this had been followed and family members confirmed that they were always updated when their relative had an accident.

The provider notified CQC of all significant events and the home's previous inspection rating was displayed within the entrance of the home and on the provider's website.