Ryde House Homes Ltd

Ryde House Outreach Service

Inspection report

Binstead Road
Ryde
Isle Of Wight
PO33 3NF

Tel: 01983817094
Website: www.rydehouse.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Ryde House Outreach provides support to people, living with a learning disability, to access the community and provide respite for their main carer. At the time of our inspection the service was providing support to 31 people within the community. However, only four of those people were receiving a personal care service, which is regulated by the Care Quality Commission and subject of this inspection.

The inspection was carried out by one inspector on 18 May 2017 and 23 May 2017. The provider was given two days' notice because the location provides a domiciliary care service; we needed to be sure someone would be in.

The service did not have a registered manager. This was because the previous registered manager had recently left and the manager who had taken over had not yet completed their 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 home is run.

The systems in place to monitor the quality and safety of the service were not robust. People were supported by staff who understood their needs. However, their care records were not always personalised, accurate or up to date.

Although staff followed legislation designed to protect people's rights, the assessment of their capacity and how they make decisions was not always documented.

People were supported to take their medicine by staff who had been trained and assessed as competent. However, best practice guidelines were not always followed in respect of hand written documentation and the use of pain assessment tools.

The new manager, who had been in post for four weeks, had recently completed an audit of the service, which they presented to the provider. Although the manager had identified these areas for improvement during their audit it was too soon for all of the actions to have been completed and the new practices to be embedded into the service.

People's families told us they felt their relatives were safe. Staff and the 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.

People were supported by staff who had received an induction into the service and appropriate training, professional development and supervision to enable them to meet people's individual needs. There was enough staff to meet people's needs and support them to engage in the activities they wanted to do.

Staff were aware of the risks relating to people and how to manage them. Healthcare professionals such as GPs and district nurses were involved in people's care when necessary.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect.

There was an opportunity for people's families to become involved in developing the service and they were encouraged to provide feedback on the service provided through spot checks and service reviews.

People's families told us they had seen an improvement since the new manager had arrived and felt the service was well led. The provider had arrangements in place to deal with any concerns or complaints.

Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the service.

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

People were supported with their medicines by staff who had been trained and assessed as competent. Actions to improve the management of medicines were on going and not yet fully embedded into daily practice.

People's families felt the service was safe; staff were aware of their responsibilities to safeguard people.

Staff were aware of the risks relating to people and how to manage them. The manager had assessed individual risks to people and taken action to minimise the likelihood of harm.

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 consent from people before providing care. Actions to improve the records relating to legislation designed to protect people's rights were on going and not yet fully embedded into daily practice.

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

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

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, and when appropriate their relatives, were involved in developing their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always were personalised and focused on individual needs and goals.

Staff were responsive to people's needs and supported people to engage in activities they enjoyed.

The manager informally 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?

Requires Improvement

The service was not always well-led.

The systems in place to monitor the quality and safety of the service were not robust.

There was a clear management structure and the provider's values were clear and understood by staff.

People's families and staff had the opportunity to become involved in developing the service.

Ryde House Outreach Service

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.

The inspection was carried out by one inspector on 18 May 2017 and 23 May 2017. The provider was given two days' notice because the location provides a domiciliary care service; we needed to be sure someone would be in.

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.

At the time of our inspection Ryde House Outreach service was providing support to 31 people within the community. However, only four of those people were receiving a personal care service, which is regulated by the Care Quality Commission and subject of this inspection.

People using the service were unable to verbally communicate with us. We spoke with the families of the four people using the service and receiving personal care. We spoke with the manager, a co-ordinator, four care staff, the HR manager, the training lead, the safeguarding lead and the provider's representative. We also spoke with two care professionals.

We looked at care plans and associated records for four people using the service, and records relating to the management of the service. These included staff duty rota records, staff recruitment files, records of

complaints, accidents and incidents, policies and procedures, and quality assurance records.

Good

Is the service safe?

Our findings

The families of the four people using the service told us they felt their relatives were safe. One family member said their relative was, "Safe here; you can go off and relax". Another family member said, "[My relative is safe, they have risk assessments to make sure". A third family member told us their relative felt safe, "Because he rejects those [members of staff] where he doesn't feel safe". A care professional said, "[The manager] is very good, people are absolutely safe".

People were supported by staff who had received medicines training and had had their competency to administer medicines assessed to ensure their practice was safe. The service had a clear medicines policy and there were arrangements in place to support people with regard to their medicines. At the time of our inspection staff were only supporting people with 'as required' (PRN) medicines, such as pain relief, occasionally when they accompanied them out in the community or to a day centre. Although the service did not use a recognised pain assessment tool, they did have information in people's care plans which explained how staff would identify if the person was in pain. These included facial gestures and physical mannerisms. PRN medicines were stored in the person's home and care staff collected the medicines and relevant medicines administration records (MAR) when they collected the person for their visit. Some MAR charts were hand written however these were not always counter-signed, in line with best practice, to confirm hand written MAR charts were completed correctly.

The new manager, who had been in post for four weeks, had recently completed an audit of the service's medicines management. They had taken action to rectify those areas where best practice was not being followed. During the inspection we identified that improvements had been made but it was too soon after the changes for the manager to demonstrate that the new practices were embedded into daily practice. We have addressed this in the well-led section of the report.

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 manager had received safeguarding training. One member of care staff gave us an example of where they had identified and raised a safeguarding concern in respect of a person they were supporting. They told us their manager was responsive to the concerns they had raised and said, "[The manager] is very hot on it". We looked at safeguarding records and saw that this concern had been raised appropriately with the local authority adult safeguarding team. Another member of staff told us, "I have recently had safeguarding training and would keep chasing [if I raised a safeguarding concern] if nothing was happening with it". A care professional confirmed that the manager had appropriately raised a number of safeguarding concerns. The provider had identified a safeguarding lead for all of their services. All safeguardings were passed to the lead who carried out an internal analysis of all safeguarding incidents providing a quarterly report identifying patterns and trends which were fed back to the provider and the training manager.

People were supported by staff who knew them well and understood the risks related to their care. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. For example one staff member was able to explain the risks relating to one of the people they

supported when they were out in the community. The manager had assessed the risks associated with providing care to each individual; these were recorded along with the actions identified to reduce those risks. Individual risks to people were managed effectively and people were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example one person who occasionally displayed behaviour that staff or other people may find distressing had a risk assessment in place to enable them to go swimming in the community. Other risks were also managed effectively. For example, risks relating to travelling in a vehicle, choking, falling and those relating to people's home environment.

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 the manager to review all incidents, accidents and 'near misses'. The HR manager also carried out analysis on the information and provided a report to the provider, senior managers and the manager enabling learning and risk identification across all of the provider's services.

There were sufficient staff to meet people's needs. The manager told us staff allocation was based on each person's needs. These were assessed, in conjunction with their care manager and family, prior to acceptance by the service. Each person had an individual staffing plan which identified the level of support they needed dependent on the activities they were engaged in. The provider had a computerised people planner system, which detailed the staffing requirements for each day. Short term absences of staff were managed through the use of overtime and the co-ordinators, in negotiation with people's families. Each person had a core team of care staff who worked with the person; if a member of the core team was not available to cover short term absence then the family was consulted as to whether a non-core team member would be used to support the person or not.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's HR manager in conjunction with the outreach manager. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were plans in place to deal with foreseeable emergencies, such as an adverse weather plan. This was linked to the 'People Planner' system where people had been assessed as a high or medium priority risk based on their needs and their family support structures. There was also a paperwork back up of key information in case the electronic system failed.

Good

Is the service effective?

Our findings

People's families told us they felt staff understood the needs of their relatives and had the skills to support them effectively. One family member said, "Staff are really good. It is so important to have staff who are experienced and understand [my relative's] needs". Another family member told us that staff, "Understand [my relative's] needs and how to look after [them]". A third family member said, "The younger staff are really good and can relate to [my relative]". The care professionals we spoke with told us they did not have any concerns regarding how people's needs were met. One said, "Staff are very flexible. People [they are supporting] are challenging; they take on board people's needs as a team and deliver the whole package. Very good".

People were supported by staff who had received training in respect of the Mental Capacity Act, 2005 (MCA) and were able to demonstrate an understanding of how it applied to the people using the service. However, although people's ability to make decisions was assessed in line with the MCA this was not always documented in people's records. 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 new manager, who had been in post for four weeks, had recently completed an audit in respect of compliance with the MCA. The audit identified the need to provide 'clearer information around the individual's capacity and how they make decisions'. The manager had taken action to improve compliance with the MCA through the introduction of a 'My life, My choice' support plan for each person. This plan identified key aspects of people's care, which required consent or a best interest decision, such as support with medicines and the gender of the staff providing personal care.

The provider had agreed to the adopt the use of the new 'My life, My choice' support plan, which was being implemented across all of their services. During the inspection we identified that the new support plan was being included within people's care records. However, it was too soon after the changes for the manager to demonstrate that these new practices were fully implemented and embedded into daily practice. We have addressed this in the well-led section of the report.

People's families told us that staff sought their relatives consent before providing care or support. One family member said, "If [my relative] doesn't want to do something [they] will definitely let them know". Daily records of care showed that where people declined care this was respected.

People were supported by staff who had received an effective induction into their role. Each member of staff had undertaken an induction programme which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. One new member of staff told us that, "I had a good induction; I had an information pack and e-learning. I had [named person] as my mentor who was there to support me. Then I did shadowing and was given people's

care plans to read, which I found really useful". Another member of staff said, "Training is very good. I did the care certificate as a refresher and found it very helpful".

The provider had an electronic system to record the training that staff had completed and to identify when training needed to be repeated. The provider's training lead explained the new electronic system, which identified compliance with the expected training schedule, using a red, amber, green traffic light alerting system. The percentage compliance of staff within the service was one of the manager's performance indicators.

The training available included essential training, such as medicines awareness, safeguarding adults, moving and handling and infection control. Staff were also supported to access specific training to support their role including: autism awareness, dementia awareness, Mental Capacity Act and PROACT SCIP training, which provides staff with a positive range of options for crisis intervention and prevention when supporting people who occasionally displayed behaviour that staff or other people may find distressing. Staff were offered training in a variety of formats to meet their individual learning styles and subject matter. These included practical face to face workshops and individualised e-learning. One member of staff told us, "The training is pretty good. There are really hot on making sure we are all up to date. We get email reminders when our training is due". They added "It is a good mix of face to face and e-learning. [Our trainer] is very good you can go and ask him questions any time if you are not sure". Another member of staff said, "The hands on training for manual handling was very helpful with the people I am supporting . I am down for autism training soon". A third member of staff told us, "I found the PROACT SCIP training very useful when supporting people with challenging behaviour. I learned that there is always a reason for the behaviour and it is their form of communication".

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervisions provided an opportunity for the management team to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us, "I have supervisions with [the manager] but you can also have one anytime if you want one, if you need to discuss anything". A new member of staff said, "I have had one supervision so far but if I had any concerns I know I can go to [the manager] at any time".

Before commencing with the service, staff undertook a pre-assessment with the person and their family to identify their individual needs, their personal preferences and any risks associated with providing their care. This included their medical history, an assessment of their ability to communicate and information about their mobility needs. The pre-assessment gave the provider the opportunity to ensure they had the staff with the appropriate skills and experience available to meet the person's needs and provided a risk assessment in respect of their care and support. Staff told us if they had any concerns regarding people's care they would contact the office and request a review.

Where people required support with their nutrition and hydration, this was documented in their care plan. Staff were aware of people's like and dislikes and encouraged them maintain a healthy, balanced diet based on their individual needs. All staff had received food hygiene training to ensure that food was prepared appropriately.

People were supported to access healthcare services when needed such as GPs, district nurses and chiropodists to ensure people received a consistent approach to their healthcare.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One family member said their relative, "Loves being with [her care staff], gardening and out in the community as well. [My relative] has built up a good bond with people. [They] have a happy time with them [the care staff]". Another family member told us, "[My relative] is very happy when out with [care staff]. I have no concerns he is very settled". The care professionals told us staff were caring and patient when supporting people. We observed staff engaging with one person and although they were unable to verbally communicate they were able to understand what was being said and make their wishes known. The member of care staff was patient and supportive when engaging the person who was relaxed in their presence and appeared happy.

People were supported by staff who understood the need to treat people with respect and dignity. One family member said, "Staff definitely treat [my relative] with respect". Another family member told us, "I have no concerns they are very caring and respect [my relative's] dignity". A member of staff said, "If I have to support [named person] with their personal care when we are out, we go somewhere private and I make sure the door is closed and they are comfortable". A second member of staff told us, "If I am supporting people with personal care I make sure doors and curtains are closed and keep them as covered up as possible". The staff knew people's routines and abilities and encouraged people to be as independent as possible.

Staff understood the importance of respecting people's choice and their right to refuse care. When a person declined care this was recorded in their daily record of care. One family member told us their relative can be "difficult" and "change their mind". They said, "Staff are very patient with [my relative] and they tell me if he refuses anything".

People, and when appropriate their relatives, were involved in developing their care plans. One family member told us, "We are involved in [my relative's] plan". They added, "They [staff] give us feedback about how things are going, so we can say if we are concerned". Another family member said, "[My relative] is involved [in their care]; they choose who supports them and rejects those [they] don't like". The manager told us they were in the process of upgrading people's care plans to ensure the care provided was centred on the person as an individual. The new care plans contained information such as the person's personal history, their likes and dislikes and their hobbies and interests. People's preferences and views were reflected in their care plans, such as the name they preferred to be called and their choice of the gender of the person providing care.

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

Requires Improvement

Is the service responsive?

Our findings

People's families told us they felt the service was responsive to their relatives' needs. One family member said, "They [the management team] are definitely responsive to concerns and [my relative's] changing needs". Another family member told us they had had problems in the past when they "Felt they [management] weren't listening to us". However, they added "Now [the new manager] is here things have improved. She is very good and communicates with us; we feel we are getting heard now". Care professionals told us staff were responsive to the changing needs of the people they supported. One care professional said, "[The new manager] is very good. She works with family members and takes on board the wishes of the individual and works with the individual and their family".

People's care plans were goal focussed and provided information to care staff as to what support the person needed to help them work towards their goals. For example one person's goals included 'I would like to not use my blue moving and handling belt as often as possible' and 'I would like to improve my social skill'. We spoke with the staff who supported this person and they told us the action they took to encourage them to work towards these goals. Each person's care file contained an average day plan, which described people's daily routines and provided care staff with information of what people liked to do and the support they needed.

However, we found that people's care files were not always focussed on the individual, for example, one person had an allergy but there was no information in the care plan as to the severity of the allergy or how it affected them. The care plans were also not always accurate and provided conflicting information to staff. For example, one person's care plan stated they did not receive any medicines but later in the plan it identified that they took pain relief on an 'as required' basis. The person had a goal of 'I would like to access new vehicles and be encouraged into them'. However, in the support needs section of their care plan it stated care staff will 'only use the Renault scenic [when taking the person out]'. We pointed this out to the new manager, who had only been in post for four weeks. They had recently completed an audit of the service and identified that care plans were 'a little disorganised' and 'lack a person centred approach'. They had an action plan for reviewing all of the care plans but this had not been completed at the time of our inspection.

All four people who used the service had communication difficulties and were unable to verbally communicate. Staff were able to demonstrate their understanding of people's needs and how best to communicate with each person they cared for. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. Each person had a communication passport which provided staff with information of how the person preferred to communicate and guidance on their non-verbal communication. For example one person's guidance stated, 'I can respond to direct questions by tapping my mouth or making unique noises' and 'I laugh when I am happy and slap inside my legs; If unsettled I will clap my hands or twitch my neck'. The staff were knowledgeable about the people they supported and the things that were important to them in their lives. People's daily records of care showed care was being provided in accordance with people's needs and

wishes.

Each person had an allocated keyworker, who was also the team leader of their core team who supported them. Their role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. One member of staff told us they were a keyworker for one of the people and said, "The role of the keyworker is to focus on the person and make sure their care plan is up to date. They are the person [staff member] other members of the core team can go to for knowledge about the person [we are supporting]". A family member told us, "[The new manager] is going to appoint a keyworker [for my relative] who we can talk to".

People were provided with appropriate mental and physical stimulation. People had access to activities that were important to them. Some of the people were supported to attend a day centre and Willow Village, which is a project on the provider's site providing meaningful and fun activities for people living with learning disabilities. Activities included, arts and crafts, gardening, up-cycling, computers and games consoles and the use of sensory equipment. Other activities included, swimming, going for walks, visiting the beach, cafes and other leisure areas. One family member said, "[My relative] loves coming here [Willow Village] and going out in the community as well". They added their relative "Has a happy time when [they] are here with their carer".

People's families were given the opportunity to provide feedback on the service on an informal basis through 'service review' meetings, spot checks and during telephone contact and face to face meetings with senior staff. The information gained from the 'service review' meetings was recorded and kept within the person's file. On reviewing this documentation, the feedback was positive and comments included 'Staff are well trained', 'rated as excellent', 'good as gold, [named staff member] is incredible' and 'always helpful and on time'.

The provider also sought formal feedback about the service through the use of quality assurance questionnaire, which was sent out to people's families. However, we found that no formal questionnaire had been sent to people or their families for nearly two years. We raised this with the manager who told us they had identified this as part of their recent audit and were speaking with the provider to arrange for a questionnaire to be sent out.

People's families told us they knew how to complain and confirmed that the management team responded well to any complaints. One family member said, "I am confident that if I needed to raise something with [the new manager] she would sort it out for me". A care professional told us, "[The new manager] is flexible and responsive to complaints and works with families to sort things out".

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people and their families could take if they were not satisfied with the service being provided; this information was also available in the 'service users' guide' which was provided to all people using the service or their relatives. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. This was because the previous registered manager had recently left and the manager who had taken over had not yet completed their 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 home is run.

People's families told us that since the new manager had taken over they felt the service had improved and was well led. One family member said, "Ryde Outreach has been brilliant in responding when things haven't been right. [The new manager] is doing her very best". Another family member told us, "I have no concerns now. Very good". A third family member said, "Generally, I am feeling good about the service now". The care professionals told us they felt the service was well led. One said, "It is absolutely well led. [The new manager] is very approachable and is able to move the service forward".

However, the existing systems in place to monitor the quality and safety of the service provided were not robust and did not identify the concerns we found during the inspection. When the new manager took on the role they carried out a comprehensive audit of the service. During the inspection we identified some care plans were not always personalised, accurate and up to date. We also found that information relating to people's ability to make decisions and the decisions made in their best interest were not always recorded. Additionally, best practice guidelines were not always followed in respect of hand written documentation and the use of pain assessment tools for the administration of medicines.

Although the manager had identified these areas for improvement during their audit it was too soon for all of the actions to be completed and the new practices to be embedded into the service.

The provider was in the process of enhancing their quality assurance processes across all of their services, which included the creation of a specific quality assurance post, and peer to peer quality assurance inspections involving managers from each of the provider's services inspecting another of their services. They were also developing a quality assurance oversight group, including the safeguarding lead and the training lead to assess quality across all of the provider's services.

The manager had commenced a series of audits, including reviews of medicines management, care files, supervisions, training and used the feedback from spot-checks to understand the quality of the service provided. Where issues or concerns were identified remedial action was taken. For example, during one spot check they identified that a car being used to support a person to access the community was defective and took appropriate action.

There was a clear management structure, which consisted of the chief executive officer (CEO) who is the provider's representative, the manager, the co-ordinators and senior care staff. Staff were confident in their role and understood the part each person played in delivering the provider's vision of high quality care. The

management team encouraged staff and people to raise issues of concern with them, which they acted upon. One member of staff told us, "This is a great place to work. The seniors and management are very approachable and you feel they do listen to what you have to say". Another member of staff said, I am well supported. The management are nice people; asking if you are okay". A third member of staff told us they felt the service was, "Well led; you feel supported by [the management team] even out of hours". A different member of staff said, "They look after the staff and the people [using the service]; it is fantastic".

The provider was fully engaged in running the service through the CEO and their vision and values were built around providing dynamic support to people with learning and physical disabilities promoting their personal growth, independence and enhancing their wellbeing. Staff were aware of the providers' vision and values and how they related to their work. One member of staff told us, "We focus on the person. We make sure we know what they like to do and how to support them". Another member of staff said, "I try and encourage [person] to do things for themselves, in line with their goal". They then gave us an example of what the person had achieved towards their particular goal.

Regular staff meetings provided the opportunity for the manager to engage with staff and reinforce the providers' values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member told us, "Staff meetings are useful but there is never enough time as everyone has their say". Another member of staff said, "We have staff meeting s every two months and core team meetings. There are very good".

The manager was accessible to people, their families and staff enabling and encouraging open communication. People's families told us that they were given the opportunity to provide feedback about the culture and development of the service. A member of staff said, "I like working here; good atmosphere, good team; I like coming to work". Another member of staff told us, "It is a difficult service to manage because of the clients' needs. We have very good staff; lots of trust. [The new manager] has made a big difference".

The providers had suitable arrangements in place to support the manager, for example regular meetings, which also formed part of their quality assurance process. The manager confirmed that support was available to them from the provider, through the CEO. They told us they could also "Pop in and see" any of the provider's other senior managers and discuss issues and concerns at a monthly managers meeting.

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

Although the manager, who was in the process of registering with CQC, was not yet registered they understood the responsibilities of the role and were aware of the need to notify the Commission of significant events in line with the requirements of the provider's registration. They also understood and complied with their responsibilities under duty of candour.