Ryde House Homes Ltd

Ryde House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 and 29 January 2016 and was unannounced. This was the first inspection of this service since the change of name of the provider organisation in July 2015.

Ryde House provides accommodation and support for up to 64 people, who have a learning disability or an autistic spectrum disorder. Accommodation was provided for people in four purpose built properties and the main older building, which were all run as independent homes within the grounds of Ryde House. People were able to access large grounds and a private beach.

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

People were not always protected from the risk of infection as infection control risk assessments were not regularly carried out to mitigate all risks. Infection control practices used by staff placed people at risk of harm from infection.

Appropriate arrangements were in place to manage most medicines safely. However, temporary arrangements for the storage of medicines in one house were not appropriate and needed to be replaced to meet legal requirements. In one instance, guidelines were not clear on when an 'as required medicine' should be administered. as part of a strategy to support a person when in crisis.

People's capacity to make effective decisions was not always assessed and decisions made on behalf of them may not have been in their best interests. Relevant legislation was not being used effectively to protect the rights of individuals.

Staff did not always receive essential training, which the provider had identified as being required, to be updated annually. This meant care provided may not have reflected changes in law and guidance.

The provider was unaware of their legal obligations to notify the commission of certain incidents and had failed to do this when required. The provider was not taking effective measures to monitor the quality of the service overall.

Risks associated with the delivery of care were assessed and action plans were prepared to identify how to keep people safe when receiving care and support. Environmental risk assessments identified how to keep people safe in the home and surrounding environment.

Staff had received training in safeguarding people from abuse. They knew how to report concerns and who they should report those concerns to. The provider responded to reports of abuse and ensured they were

managed appropriately. People and their relatives told us there were sufficient staff on duty to meet people's identified care needs.

People received sufficient to eat and drink. Meals and drinks were nutritious and based on people's individual choices and known preferences. People were able to access suitable health care treatment and assessments when required.

People and their relatives told us they had positive and caring relationships with staff and managers of the service. We observed staff were friendly, approachable and attentive to the needs of people. They were aware of how to maintain people's privacy and dignity and ensured they knocked on doors and waited for a response before entering their room.

Staff knew the people they supported well. They knew how people communicated and supported them to make choices with their care based on their knowledge of the person, their likes, dislikes and how they demonstrated positive or negative responses.

People's needs were assessed when they moved to the service. This assessment was regularly updated to include any changes to the person's needs. Where people's needs had changed, plans were prepared to ensure they received any necessary extra support.

Care plans were personalised and reflected the individual's needs, likes and preferences. These clearly identified the support the person required and what the outcome of interventions should be for the person.

People were asked for their opinion of the care and support they received and were able to make complaints if needed. Action was identified by the provider of improvements required, although in one instance staff were unsure if the action taken had been effective.

There was a positive culture within the service and staff found their managers approachable and open with them. Staff were aware of the vision of the service to support people to be as independent as they could be.

The provider had a development plan in place to improve aspects of the service and involved staff in preparing guides for practical activities of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risk of infection as infection control risk assessments were not regularly carried out or covered all risks. Some infection control practices used by staff that placed people at risk. Risks associated with the delivery of care were assessed and action taken to ensure people's safety.

Staff had received training in safeguarding and knew how to report concerns. The provider responded to reports of abuse and ensured they were managed appropriately.

There were sufficient staff on duty to meet identified support needs. Medicines were administered and recorded appropriately and the manager was taking effective steps to improve the storage of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make effective decisions was not always assessed and staff were unable to show that decisions made on behalf of people had been taken in their best interests.

Staff did not always receive training or updates on training when they required it.

People were supported to receive sufficient meals and drinks that were nutritious and based on their choices. People were able to access suitable health care treatment and assessments when required.

Is the service caring?

Good

The service was caring,

People and their relatives told us they had positive and caring relationships with staff and managers. Staff were friendly, approachable and attentive to the needs of people.

Staff knew how people communicated and supported them to make choices. Care and support were delivered based on staff knowledge of the person, their likes and how they demonstrated positive or negative responses.

Staff were aware of how to maintain people's privacy and dignity and ensured they knocked on doors and waited for a response before entering their room.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed regularly to identify any changes to needs. Where people's needs had changed, plans were prepared to ensure they received any necessary extra support.

Care plans were personalised and reflected the individual's needs, likes and preferences. These clearly identified the support the person required and what the desired outcome of interventions for the person.

People were asked for their opinion of the care they received and were able to make complaints if needed. Action was identified by the provider of improvements required, although in one instant staff were unsure if the action taken had been effective.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider was unaware of their legal obligations to notify the commission of certain incidents, and had failed to do this when required. The provider was not taking effective measures to monitor the quality of the service overall.

There was a positive culture within the service and staff found their managers approachable and open with them. Staff were aware of the visionof the service as to support people to be as independent as they could be.

The provider had a development plan in place to improve aspects of the service and involved staff in preparing guides for practical activities of care.

Ryde 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.

The inspection took place on 28 and 29 January 2015 and was unannounced. The inspection team consisted of three inspectors and one specialist advisor whose area of specialism was in working with people with learning disabilities, autism and behavioural difficulties.

This inspection was brought forward in light of concerns made aware to us by the local authority. We looked at previous inspection reports prior to our inspection. we looked at notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 10 people who lived in the services on the Ryde House site. We also observed elements of care and support provided to people by staff. We spoke with four relatives of people, 19 members of staff and a visiting healthcare professional.

We looked at 13 people's care plans and care records. We saw 10 members of staff's recruitment and support records. We looked at some of the provider's policies and procedures, training and quality monitoring records. We looked at feedback the provider had received and how they managed complaints.

Requires Improvement

Is the service safe?

Our findings

The provider was not able to demonstrate that the risks of people acquiring an infection had been identified, assessed and managed effectively. Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments were in place, and any staff training or outbreaks of infection that had occurred. The provider had not completed an annual statement. The infection control risk assessments we viewed did not cover all relevant risks, such as those posed by bathrooms and toilets or while staff were supporting people with their personal care. The code also requires providers to conduct infection control audits. These had not been completed, but a senior manager showed us an infection control audit tool they were planning to introduce shortly after our inspection.

Staff had received training in infection control but did not always follow safe working practices to prevent the spread of infection. Each house had its own purpose-built laundry and this provided some resilience when machines broke in other houses. On the day of our inspection, four washing machines or tumble dryers had broken down at the same time and staff were transferring laundry between houses to either wash or dry it. Washing from a house where some people had had a sickness bug had been transferred to a second house for drying. When we viewed the laundry room in the second house we saw there was no process in place to ensure that clean laundry was not contaminated by dirty laundry or that potentially infectious washing from the first house was kept separate from washing from the second house. The laundry room floor was covered in piles of mixed washing, as the laundry storage trolleys were full. On top of one of the piles was a red, soluble bag containing potentially infectious linen that had not been tied; its contents were at risk of falling out and contaminating other laundry.

Staff had a schedule of cleaning tasks to perform each day and these were monitored through the use of daily checks on a hand-held computer. However, these were not always completed in one house, including for a seven day period in January. Therefore, the provider was not able to confirm that cleaning had been completed in accordance with the schedule.

Staff washed their hands before preparing food, but some used the main kitchen sink, which contained pots and pans awaiting washing, rather than the dedicated hand washing sink.

People's rooms, bathrooms and communal areas of the houses were clean. However, one of the lounges smelt of urine and there were items of clothing and dirt behind the washing machine in one of the houses.

The failure to manage infection risks effectively was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe procedures in place for obtaining, administering and disposing of medicines and people received their medicines when required. An effective system was in place to monitor and account for all

medicines received into each house through clear stock control systems. These included a clear process to help ensure topical creams were not used beyond their 'use-by' date. However, the storage facilities for medicines that were subject to additional control by law were not adequate in one of the houses. A senior staff member told us such a storage facility had not been required previously as people did not require these medicines. Recently one person had been prescribed these medicines and facilities had been put in place as an emergency measure. They agreed to review the long term storage arrangements for these specific medicines.

Information was available to advise staff when to administer "as required" (PRN) medicines, such as sedatives after other strategies had not been effective in supporting the person. However, staff were not always clear about how long they should wait after administering one dose of a PRN medicine before administering another, and there was no guidance recorded about this. We discussed this with one of the managers who said they would seek advice from a community health professional and update the person's records.

One person told us, "I feel safe at the home and receive my medicines when I need them." Another person said, "Staff help me with my medicines and make sure I have them when they are due." We heard one person asked a member of staff for some paracetamol as they had a head ache. There were clear guidelines in the person's care plan, which staff checked before administering the medicine. One person required their medicines to be given through their Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. Guidelines in the person's care plan and medicine records were followed by staff and this was given safely.

People said they felt safe. Comments included, "I like living here, it is a safe place." "Staff help me to keep safe." However, one person said they did not feel safe and said this was due to another person they lived with. We discussed this with the manager of the house who explained that action had been taken to provide the other person with a separate lounge area for them to be be supported by their allocated member of staff.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One staff member told us, "If I had any concerns I'd report it to [the house manager]. I know I'd get a good reception and they would deal with it." Staff had received appropriate training and were aware of people who were at particular risk of abuse. However, the provider's safeguarding policy was a generic care home policy. It did not reflect the specific risks to people living at the service or the provider's arrangements for reporting and analysing incidents of abuse that occurred. We had been made aware of safeguarding referrals made by the provider to the local authority safeguarding team. There were records of actions agreed with the safeguarding team and the provider was engaged in safeguarding reviews.

The manager of each house was responsible for reporting allegations of abuse to the local authority and this was done promptly when required. The provider responded appropriately to any allegation of abuse by conducting thorough investigations and liaising with the local safeguarding team. All safeguarding incidents were reviewed by the Chief Executive Officer (CEO) and analysed for trends, such as common times, places, people or staff, so that changes could be made to reduce the likelihood of further incidents. The CEO said, "We can't eliminate all risk, but we can try to reduce it. It could be that the mix of people in one of the houses is not right or that the person supporting the client is not a good fit for that person."

Staff looked after small amounts of money for some people. Suitable measures were in place to keep this secure and record its use; the records were then audited regularly by the provider's finance team. Staff described the process for recording money received and spent for people and the logging of receipts to show how people had used their monies. This helped protect people from the risk of financial abuse.

Individual risks to people were managed appropriately. One person liked to prepare meals, but a recent review of this showed it was not safe for them to enter the kitchen or use knives. Staff supported the person to continue to make meals outside of the kitchen. A staff member told us "[The person] still prepares meals but we do the cutting up and give the prepared ingredients, like sliced onions to them. It gives [the person] the independence of completing the task without the risks involved." The person also used a plastic cup for drinks as this reduced the risks to themselves and others. Individual risk assessments seen in care files had been reviewed and were relevant to the person. One person spent a lot of their time using a wheelchair which had been specially designed for them. We saw they were also using a pressure relieving cushion to minimise the risk of developing pressure injuries.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staffing levels were determined by the number of people using the service and their individual needs, and staff worked flexibly to meet people's needs. Some people required one to one support throughout the day. A list on the office wall showed which member of staff was allocated to support each person. A staff member told us, "We change our [working] days all the time according to the clients' needs and what they want to do. For example, one person goes to the swimming pool and our hours are based around when they can use it." Staff said they sometimes worked extra shifts if another member of staff was off sick or on holiday. This ensured people were supported by staff who knew them well.

There was a clear process in place to recruit staff which helped ensure they were suitable for their role. The provider carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. As part of the recruitment process, staff were invited to spend a few hours observing how experienced staff supported people. This gave them an insight into the role and allowed people and existing staff to feedback on how the potential recruit had interacted with them. Staff confirmed this process was followed before they started working at the home.

Arrangements were in place to deal with foreseeable emergencies. Fire evacuation bags containing emergency equipment and information were kept in each home. These included details of the support people would need if the building had to be evacuated. The service had recently purchased a defibrillator that was kept in an accessible place. A sufficient number of staff had been trained to operate this and to administer first aid in an emergency. Emergency plans included arrangements for reporting people missing; an up to date photograph and description were kept in their care plans to assist the emergency services to find them. There was appropriate equipment in all areas to lift people from the floor if required. Staff said they would evacuate people if needed to the management offices or another house.

We found in two houses that not all upstairs windows had window restrictors in upstairs rooms. This was pointed out to the managers of those houses and to the provider. They were aware of these and had ordered new window restrictors. They were waiting for these to be fitted.

Requires Improvement

Is the service effective?

Our findings

People's ability to make decisions was not assessed in line with the Mental Capacity Act, 2005 (MCA). The Mental Capacity Act 2005 (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 made on their behalf must be in their best interests and as least restrictive as possible. We saw staff were following these principles on a day by day basis. However, there was a lack of information in care plans about people's ability to make decisions. Consultation with family members and other professionals had occurred for some people but not others. Where consultations had occurred this had not been recorded in a best interest decision making format and had not been preceded by an assessment showing that the person was not able to make the decisions themselves. This meant that some decisions had been made for people without their consent or could be shown to be in their best interest. For example we observed one person being given their medicine on a spoonful of yoghurt. Their care plans did not say the person agreed to this and there was no record of who had been consulted on this practice. Whilst this was not a covert administration of medicine there was no record of the safety of this. Records did not show if there was a possible interaction between the medicine and the yoghurt. This may have affected how this medicine worked for the person receiving it. Senior managers showed us work in progress to incorporate MCA within a new care planning system. Once in place this would meet the requirements of the MCA.

The failure to assess people's mental capacity and document best interest decisions for people who lacked capacity was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always receive essential training to ensure they remained up to date with best practice guidance. The provider required all staff to attend a range of 'mandatory' training, including moving and repositioning; safeguarding; infection control; and the Mental Capacity Act. Their policy required staff to refresh this training on a yearly basis. Some staff, including the managers of two of the houses had not received refresher training in fire safety awareness or moving and repositioning for over three years. Other staff had not refreshed their training in the management of behaviours and crisis for up to three years. Consequently, staff may not have been aware of, or using, up to date techniques that supported people most effectively. The training used by the provider identifies a range of strategies and techniques to prevent people from going into crisis or to support people during times of crisis when they present a risk to themselves or others. The CEO told us it was used on a daily basis as an essential part of the support given to people. They said refresher training had not been completed as their focus had been on rolling out a basic level of training to all staff first. This had been completed and they planned to start refresher training in the near future.

New staff completed a comprehensive induction programme before working on their own. A new member of staff told us "The training has been good; staff have been really good to me." Arrangements were in place

for staff new to care to complete the Care Certificate while being supported by an experienced staff member acting as their mentor. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate support to people. Most staff had also obtained, or were working towards, vocational qualifications in health and social care.

Staff told us they were supported appropriately in their role and felt valued. A staff member said, "I love working here and feel very supported." Staff received regular supervisions and yearly appraisals. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "We discuss what's going well; what's not going so well; anything that can be improved; plans for clients; and training needs." The provider had also employed a counsellor to support staff in their work; staff told us they valued this service and said it was well-used.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). 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 DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were able to give clear accounts of the meaning of DoLS and how these might affect people in their care. Where necessary applications had been made to the local authority for an assessment under the DoLS legislation. For one person, for whom a DoLS had been approved, the relevant documentation was in place. We saw action had been taken to enclose a large garden to provide the person with the opportunity to access the outside in a safe and least restrictive way as possible.

Before providing care and support to people, we saw staff sought consent from people either verbally or by observing their body language. A staff member told us "We always ask for consent in advance. Everything is done in the best interests of the client." Another staff member said, "The clients are very good with medicines and are happy to take them" but added: "[One person] has complex needs, so would have very limited understanding [of their medicines] and probably wouldn't understand about the side effects." We observed staff sought consent from people using simple questions and gave them time to respond. One staff member said "If a person says that they don't want care at that time then we leave them and go back later".

People told us, "I like it all [food]; there's nothing I don't like; there's lots of it." Another said they often got their favourite foods, which were "potatoes, custard, cake and tea". Some people could help themselves to drinks and other people were offered drinks or requested drinks prepared by staff throughout the day. We observed lunchtime meals and saw people were offered choices and options of what to eat and drink. Staff asked people individually what they wanted. One person chose a type of soup. Staff were aware what they liked, as it was their favourite and said they "always make sure we have plenty in stock". Another person chose sandwiches and had choices of filling. In most of the houses lunch was a lighter meal as people had chosen to have their main meal of the day in the evening. One person told us the meal was "good" and another gave us the 'thumbs-up' sign to indicate they had enjoyed it. A further person said they were involved in cooking and could access the kitchen to make themselves a cup of tea.

People received appropriate support to eat and drink. A range of drinking vessels was provided to enable people to be as independent as possible when having a drink. This included mugs with two handles and a drinking spout for people who were at risk of spilling their drinks. A relative said "The food is good and as [relative] needs to have their food liquidised, staff manage that all ok." Staff were aware of this person's special dietary needs and described appropriately how these were met for the person's safety. Records of

food and fluids were maintained for some people which showed the types and amounts of food and drink people had consumed. Where food supplements were required these were correctly used. People's weights were monitored regularly where concerns had been identified. One house had sit on scales and scales suitable for wheelchairs. Staff said these could be shared when needed with other houses. The wheelchair scales meant it was safe and easy for people to be weighed accurately when they were unable to access other scales.

People and relatives were happy with the personal and health care provided. One person told us they could have a bath when they wanted. One relative said "[The person] always looks well groomed and [staff] are on top of his health needs" they added, "We are always told if the doctor has seen [the person] and what treatment has been suggested. Another relative told us about meetings which were held with health care professionals, staff at the home and themselves. They felt this meant everyone had an opportunity to talk about how the person should have their changing health needs met.

Care records recorded the health and personal care people received. When necessary this included records of a person's food and fluid intake, repositioning and the provision of personal and continence care. Records viewed had been fully completed and demonstrated people were receiving appropriate personal care. Those who were less mobile looked comfortable in chairs or in their beds. Care staff described how they supported people which reflected the information in the person's care plan. Specialist advice had been sought when required and we saw this was being followed. For example a Speech and language Therapist (SaLT) had assessed a person and found they required their meal in an altered format. We saw the advice was being followed and staff were aware of the person's needs. This was also the case for a person who required their drinks in an altered format. Where people had other medical needs such as diabetes, care plans contained information as to how these needs should be met and staff were able to describe the care provided. People were supported to access other healthcare services when needed. Records showed people were seen regularly by doctors, dentists, opticians and chiropodists as required.

Good

Is the service caring?

Our findings

People told us how caring they thought staff were. One person told us they were happy living at the home and said staff were "fine with me". Their room had been decorated in a style they had chosen and personalised with pictures and items important to them. They had been given a telephone with large buttons and a non-slip covering on the hand-piece to make it easier for them to use. They said, "I use it to phone my mum." Another person said "Staff are good. They look after me. I like them as they treat me well." Other comments we received from people included, "Nice place to live, staff are nice." "We can do what we want and staff always listen to us."

Communication passports had been developed to help identify the most effective way to support people to communicate. A person who was unable to communicate verbally had recently moved from one house to another on site. The staff member who had supported the person at the previous house, and knew them well, moved to the new house with them. This helped them settle in and ensured their needs were understood and met by staff in the new house. The person used a form of Makaton to communicate. Makaton is a communication system based on signs and symbols. In preparation for their move, staff had put posters of Makaton signs on the walls of the new house as a reminder for the person and for staff. A staff member told us "[The person] likes to look at the signs and will sometimes point to them to indicate what they want." The person also used the picture exchange communication system (PECS). PECS is a series of pictures that can aid communication for people living with a diagnosis of autism or learning disability. We saw sets of pictures had been put together to help the person choose their activities for the day.

Staff clearly knew the people they were supporting and understood their needs fully. They were able to tell us about people's backgrounds, likes, dislikes and preferred routines. For example, they told us about one person who liked long walks, but was not comfortable around dogs or large crowds, and the way that they expressed this fear. When looking at outside activities for this person, staff used this information to plan activities. One person told us they liked using a computer to look at maps and said staff helped them to do this. Another said they "like going to the pub" best.

We observed staff offering people choices, such as where to spend their time, what to eat and what activities they wished to do. Staff listened to people and acknowledged the responses they received. In one house we heard staff tell the manager "[The person] doesn't want to go out." The manager responded with, "Ask her again later but if she doesn't want to go we accept that and ask her what she would like to do instead." We noticed one person was an early riser waking up at 4.30am. The person liked to stay in their room and played games on their iPad. Night staff carried out regular checks to ensure the person was safe and the person's care plan identified this was their usual morning routine.

Prior to moving to the service, people, and their families where appropriate, were involved in planning and agreeing the care and support they received. One person said they had seen their care plan and staff told us of another person liked to read their care plan often. Key workers reviewed their key person's care plan every month and where possible involved the person in talking about any changes required. Keyworkers are

members of staff who take a lead responsibility for a person and their care planning. They can arrange new experiences for people and carry out reviews of care and risks with the person.

People told us they were treated with dignity and respect by staff. One person said, "This is my room and I won't let people come in if they don't knock on the door and ask if it is alright to come in." We saw staff knocking on people's doors and waiting for responses before asking if they could come in and explaining why they were there. Personal care was always carried out in bedrooms and bathrooms and staff ensured doors were shut. One member of staff said. "I always check the door is shut and the curtains are drawn before supporting someone with their personal care." However, we did see boxes of continence pads were stored in full view in some people's bedrooms, which may have caused distress to people. When we discussed this with the manager they agreed this was a dignity issue and they arranged for them to be kept in a cupboard.

Good

Is the service responsive?

Our findings

There was a lack of consistency in how complaints were managed between each of the houses within the service. We looked at records of complaints held by three houses. One house had not received any complaints. The second house demonstrated clear written responses to complaints received. For the third house, some of the responses to complaints did not show a clear process had been followed in line with the provider's policy. The provider did not carry out an audit of all complaints received to give an overview of how complaints were managed throughout the service. This meant they may have missed some opportunities to learn from the complaints received or to share the good practice observed in one house.

People and relatives told us they could make complaints if necessary. One person said, "If I am not happy about my care I will talk to the manager." A relative said, "I hope I never have to make a complaint, but if I had to I would talk to the manager or send an email to them." Information on how to make a complaint was on display in each of the houses we visited. This was in a pictorial format and located on notice boards. Family members, service commissioners and advocates received copies of terms and conditions which included information about the complaints policy. This information was clearly displayed on the provider's website, which included a spoken word version of the policy. The policy and procedure had been reviewed in February 2015 to ensure that it was current and relevant.

People were empowered to make choices and have as much control and independence as possible. Staff told us they used objects of reference to help some people make choices, such as showing them different foods that were available or pictures of activities. They would then observe the person's response to the object or picture to assess whether they were expressing a preference.

Staff were responsive to people's needs. Two people were becoming more frail and were at risk of accidents involving younger, more mobile people living in the house. Staff had identified an alternative home which may suit these people better and were in the process of introducing them to it, so they would be prepared for the move. The provider had acted to ensure a person who required specialist hospital treatment was admitted to a local mental health unit. Staff from Ryde House were providing support to the person whilst they were in hospital. The hospital had identified that the person needed the support of a specialised resource. The provider had informed relatives and the service commissioner they could not support the person effectively if they returned to the service. They were working with the commissioner to identify a suitable alternative placement that could meet the person's needs.

Care records were well organised and information was easy to find. They covered all key areas of the person's support needs, health and personal care. An assessment was included with each part of the care plan that stated what the need was and what the person required help with. This identified how support should be provided and what the desired outcome of the activity should be. Records contained in-depth information about people's needs. For example, one person's records described what vocal sounds they may make if they were uncomfortable. Care plans had been reviewed monthly and included details of the person's daily routine. This is particularly important for people with autism who may require a structured

and consistent routine to enable them to manage their day. Daily notes showed that care and support was being provided in line with people's care plans.

When people became anxious or upset, they sometimes behaved in a way that staff found difficult to manage and put themselves or others at risk. A staff member told us "We have to try and establish why they are behaving in a certain way. [One person] shows the same indicators when they are in pain as when they are anxious, so we're trying to understand the difference." Incidents where people had become anxious or upset were recorded on 'behaviour record charts' (BRCs). Examples viewed were comprehensive; they recorded when and where they had occurred; potential triggers (causes); the staff involved; the interventions used; and the outcome. They also included a section called 'reflection' which invited staff to review the incident and consider any changes that needed to be made to the person's support plan.

The provider sought feedback from people, their families and stakeholders by conducting an annual survey using questionnaires, through a link on their website and through social media. A pictorial version of the questionnaire had been developed and was being trialled in one of the houses in an effort to improve the response rate.

The most recent survey showed that 95% of respondents rated the service as 'good' or 'excellent' overall. The survey results were analysed to identify any improvements that could be made and an action plan was then developed. However, the action plan was not always monitored effectively; for example, an action from the last survey was to provide more choices of food and to review the menus. Senior staff told us the issue had been discussed at management meetings, but could not confirm whether effective action had yet been taken. Another action, to improve the maintenance reporting procedures, had been completed and managers told us repairs were now being completed more quickly.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to notify CQC of significant events, including incidents of abuse or allegations of abuse. We use this information to monitor the service and ensure they respond appropriately to keep people safe. We identified that the provider had not sent us notifications about any incidents of abuse by one person towards another person living at the service. The provider's records showed that these amounted to nearly half of all incidents that occurred at the service. We discussed this with the CEO and a senior manager who told us they had not realised that such incidents should be notified to CQC.

The failure to notify CQC of incidents of abuse or allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Each of the houses was run as a separate entity under the leadership of a house manager who was responsible for assessing and monitoring the quality of service in their house using a range of audits. Whilst there was some oversight of this by the provider, this was not always effective in ensuring the audits were completed. For example, the manager of each house was responsible for ensuring their staff attended relevant training courses, including refresher courses; but not all staff had received this training. Similarly, the house managers were responsible for making sure cleaning audits were completed; but in one house these were not always done. We discussed this with the CEO who told us about new arrangements being introduced for senior managers to monitor the performance of each house. They also showed us template forms that had been prepared for that purpose.

The provider had a Duty of Candour policy in place which required them to be open with people about serious incidents when they occurred. One person had fallen and suffered a serious injury. Staff had discussed the causes of the fall with the person and their family. However, they had not sent a written letter of apology to the person or their family, as required by their policy.

Staff praised the management of the service who they described as "supportive". Comments from staff included: "It's a good company to work for; I couldn't wish for a better boss"; "The [house] manager here is good; I love working at this house"; and "I would, and have, recommended it to friends as a good place to work".

The registered manager ensured they remained aware of each part of the service by daily briefing sessions involving all house managers. These highlighted concerns issues and activities planned for people within the service. They also carried out a regular walk through in each house , talking to staff and people who used the service. There were regular site management meetings where important issues concerning the service were discussed and ideas to improve the service were raised. The registered manager attended each person's reviews which kept them aware of each person's needs. By involving different levels of staff within working groups the registered manager was aware of issues had concerns the staff raised. All levels of management within the service attended relevant training to ensure their knowledge and practice remained up to date.

It was clear that there was a close working relationship between house managers and staff. This was helped by their offices being accessible, in the centre of the house, and an open door policy. This meant management, staff and people could interact easily and seek mutual support throughout the day. A member of staff told us, "I've got a good work group; it's a really cool team."

Staff described the vision, values and culture of the organisation as, "Helping people to have happy lives and respect the as individuals." Staff told us they "try their best to give people the best care and lives possible". Other comments showed staff were committed to supporting people to integrate into the local community wherever possible. These included, "Live life to the fullest," make this as "near home as possible", and "It's about community integration, promoting dignity and skills development."

The provider had an effective system in place to analyse incidents and accidents in order to reduce the likelihood of them recurring. This included a review of medicine administration errors. Where staff made an error, they received supervision to help ensure the error was not repeated. If the error occurred again, managers took appropriate action in accordance with the provider's discipline policy. Behaviour incident records were also reviewed by senior managers to identify any learning that could be used to help staff support people more effectively.

The provider had a development plan in place. This included a workshop group who were planning to re-structure the format of the care plans across all the houses. The service was also in the process of developing a range of "how to" guides for common procedures, such as administering medicines, which would be available on handheld computers to advise staff. A house manager showed us the plans they were developing to restructure the care planning process. This had involved care plan workshop groups with staff from all houses. The provider also had plans for restructuring the service. Two houses had been identified to be deregistered and the provider intended to register each one with the Commission as a separate service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications of abuse or allegations of abuse were not being notified to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity assessments were not completed and where decisions had been made in people's best interest these were not documented in care records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Provider failed to manage infection risks effectively