Harrison Care Enterprises Limited

Powys House Residential Home

Inspection report

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04 May 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Powys House is a privately run care home registered to provide accommodation for up to 18 people, including people living with a learning disability, autism or a mental health need. At the time of our inspection there were 16 people living in the home.

The inspection was unannounced and was carried out on 26 April 2017 and 4 May 2017.

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

At our last inspection, in February 2016, we identified breaches of two regulations; legislation designed to protect people's rights was not always followed; people did not always receive personalised care; and care plans were not always up to date and reflective of people's current needs. At this inspection we found action had been taken and there were no longer any breaches of regulation.

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

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

Staff knew the people they supported and were able to explain the risks relating to them and the action they would take to help reduce the risks from occurring. Staff sought people's consent before providing care and understood the need to follow legislation designed to protect people's rights.

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

Staff developed caring and positive relationships with people and were sensitive to their individual communication styles and choices. They treated them with dignity and respect. People were encouraged to remain as independent as possible and maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported

people, when necessary, in a patient and friendly manner.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

There was an opportunity for people and their families to become involved in developing the service. They were encouraged to provide feedback on the service provided both informally and through 'house meetings' and an annual survey. They were also supported to raise complaints should they wish to.

People told us and indicated that they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. The directors of the company were fully engaged in running the home and provided regular support to the registered manager. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

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

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

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

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

Is the service effective?

Good

The service was effective.

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

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

People were supported to have enough to eat and drink. They had access to 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 were encouraged to maintain friendships, important relationships and be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

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

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

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Powys House Residential Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and was carried out on 26 April 2017 and 04 May 2017 by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the providers to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with five people using the service and engaged with two others, who communicated with us verbally in a limited way. We observed care and support being delivered in communal areas of the home. We spoke with four members of the care staff, the cook, the cleaner, the head of care and the registered manager. We also received feedback on the service from two health professionals.

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

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said "I feel safe because there is always someone here if I need them. I can go out by myself now. I didn't used to go out but I feel safe now so I can". Another person told us, "It is safe enough; staff are around to keep you safe". The health professionals who provided feedback told us they did not have any concerns about people's safety. One told us they "felt [the home] was safe".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. All the staff we spoke with said they would initially follow the service's reporting procedure, and raise the issue with the registered manager or head of care. They also identified that they could report concerns to the local authority and the Care Quality Commission, if they wished to raise concerns in confidence. One member of staff said, "If safeguarding was about one of the staff I would go to [the registered manager or head of care]. If they didn't do anything the next step is the safeguarding team themselves". Another member of staff told us, "I would feel comfortable reporting a safeguarding [concern] to [the registered manager or head of care] and if they didn't do anything then I would report it to safeguarding myself. I have just learnt about that as part of my training".

The registered 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 in a way that helped them retain their independence and avoid unnecessary restrictions. For example, one person who occasionally displayed behaviour that staff or other people using the service may find distressing had a risk assessment in place to enable them to access the community when they wanted to.

Other risks were also managed effectively. For example, risks relating to pressure injuries, dehydration and malnutrition. Staff knew the people they supported and were able to explain the risks relating to them and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. The registered manager had also identified risks relating to the environment and the running of the home. These included fire safety, infection control, legionella and use of machinery equipment. They had taken action to minimise the likelihood of harm in the least restrictive way.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person's MAR had a sheet with a photograph of the person and information about any allergies. Records showed that people's medicines were consistently available for them. Staff made regular checks of the MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistake was found, to ensure people were protected.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines and suitable arrangements were in place for medicines which needed additional security. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored appropriately and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicines did so in a safe, gentle and respectful way. People were given time to take their medicines without being rushed. Staff explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. One person told us a member of staff "calls you and you go and they give you your medicine. I have tablets three times a day". Another person said, "Staff give me my tablets. I have one for my stomach".

People told us there were sufficient staff to meet their needs. One person said staff "are always there to ask if I want something". People told us there was always a member of staff to support them to go to the shops, attend a medical appointment or visit a family member if they wanted. The registered manager told us that staffing levels were based on the needs of the people within the home. Care staff were augmented by ancillary staff, such as a domestic, maintenance person and cook. This meant they were able to focus on providing care and engaging with the people they supported. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. One member of staff told us, "There is plenty of staff which is good". Another member of staff said, "Yes there is enough staff; we usually have more staff than not enough". There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff from another home owned by the provider or from an agency. The registered manager and the head of care were also available to provide extra support when appropriate.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. The registered manager involved people living at the home in the interview process and decisions about recruiting new staff. 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. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. Fire safety equipment was maintained and tested regularly. There was an emergency 'grab bag' in the foyer, which contained individual personal emergency evacuation plans which detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency.

Good

Is the service effective?

Our findings

At our last inspection, in February 2016, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff were not following the Mental Capacity Act 2005 (MCA). At this inspection, we found action had been taken. There was no longer a breach of this regulation and people's rights were protected.

People told us and indicated they felt the service was effective and that staff understood their needs and had the skills to meet them. One person said, "Staff know how to look after me". Another person told us, "They [staff] know me and know what I like; they help me". The health professionals who provided feedback told us staff were well trained and understood people's needs.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies and procedures; however, the recording systems for when people were not able to make decisions about their care or support were not robust. Although, the registered manager and staff followed the principles of MCA, decisions made in people's best interest were not always recorded. We raised this with the registered manager and by the second day of our inspection they had taken action to ensure all best interest decisions were being recorded appropriately.

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

People told us that staff asked for their consent when they were supporting them. One person said, "I would tell them if I don't want to do something but it doesn't come up as you only do what you want". We saw another person was still in bed at mid-morning. They told us they "didn't want to get up". We observed staff seeking consent from people using simple questions, giving them time to respond. One member of staff told us, "If they [a person] doesn't want to do something with you, I try someone else [another member of staff] or come back later. If they still don't want to do something, they don't have to". Another member of staff said, "I always ask them what they would like you to do before I do anything". 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, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training, 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. A new member of staff said, "I came here straight from college. I did my induction; went through care plans; did the care certificate and two weeks shadowing. When I had finished I felt confident to support people. I had learnt a lot". Another new member of staff told us, "I came here with previous experience in care but I found there is a difference between [supporting people with] learning disabilities and mental health, which is a learning curve for me".

The providers had a system to record the training that staff had completed and to identify when training needed to be repeated. This was in an electronic format and allowed the management team to quickly identify when staff needed refresher training and be aware of what training was occurring when. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, autism, diabetes, epilepsy and Mental Capacity Act. Staff were also supported to undertake a vocational qualification in health and social care. One member of staff told us, "We have regular training. It's good because [the registered manager] asks for feedback on the training, whether it was good or not". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a learning disability to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide 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, "We have monthly supervisions. I find them useful but I don't wait for a supervision, I raise things all the time". A new member of staff said, "I have had one supervision so far. It was nice because I got to talk quite a bit. It all seemed to go quite well".

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "The food is alright. I don't like [particular food] so they give me something else. They always give me something I like. They know what you like. I am having salad for my tea. You can choose but I wanted salad". Another person told us, "The food is nice here; I can choose what I want".

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The cook told us, "People can choose when they want to eat. Some come down [to the kitchen] and make their own sandwiches or crumpets". They told us for those people who were diabetic they prepared the same food as others were eating but used sugar substitute. There was a pictorial menu on the notice board in the dining area to help people understand what choices were available them. Meals were appropriately spaced and flexible to meet people's needs. For example one person who was due to attend a medical appointment immediately after lunch was offered their meal earlier to allow them time to eat their meal in a relaxed way without having to rush.

Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support and encouragement when appropriate. We observed one member of staff supporting a person with their meal. Although the person was not able to verbally communicate the member of staff engaged them in conversation, while explaining to the person

what the meal was and then what each mouthful of food was. They allowed the person time to eat and enjoy the food before offering the next spoonful. Drinks, snacks and fresh fruit were offered to people throughout the day.

People were supported to maintain good health and had access to appropriate healthcare services. Their care records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. One person said, "I am going to have an injection. They [staff] come with me". Feedback from health professionals included "The staff team at Powys House are receptive to the guidance [we provide]".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person told us, "I am very happy here; it's lovely; staff are nice". Another person said that staff were, "very caring; very fond of you. They make a fuss of you; there is always someone to talk to, they ask what I have been doing. They are always interested". A third person told us, "I can say to [staff] if I am upset and they look after me". Other comments from people included, "Staff are lovely", "They are very patient with me", "Happy here" and "the staff are nice". The health professionals who provided feedback told us staff were caring and patient when supporting people. One told us, "All the staff I met seemed to be caring and friendly towards residents".

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. One person told us, "They knock on my door and I say come in and they do". A member of staff said they felt that respecting people's dignity and wishes was very important and told us, "I read through their care plan to make sure I know their preferences and explain what I am doing. I make sure doors are shut and they are covered; I make sure they are happy". The health professionals who provided feedback told us staff were caring and patient and they did not have any concerns regarding how staff respected people's dignity and privacy.

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. One person told us, "You can choose what you want to do and don't have to do it if you don't want to. I don't want to do the drama today so I am not". Another person said, "If I don't want to do something they say don't worry". A member of staff told us, "If they [people] don't want to do something with you, I try someone else [another member of staff] or come back later". Another member of staff said, "I offer people choices all the time. Like [named person] I offer her two choices of yogurt. She always has chocolate but I always offer her both".

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. A member of staff told us, "The care plans help us understand people. We help them to become more independent and encourage them to do things for themselves".

People were encouraged to be as independent as possible. One person told us "I do the washing up; tidy my bedroom; do my own washing. If I need help I just have to ask". Another person said, "I do my own shopping. The girls take me out [to the shops] when I want to". A third person told us they liked to go out on the bus on their own. Other examples of people being encouraged to be independent included when staff supported

people to do their own laundry, make their own breakfasts, sandwiches and drinks, carry out domestic tasks, such as tidying their bedrooms, clearing the tables and doing the washing up.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support, which identifies people who are important to the person. All of the people we spoke with confirmed that the registered manager and staff supported them to maintain their relationships. One person told us, "Staff take me to see my [relative] who is in hospital. I used to visit him by bus when he was at home". Another person said, "My [relative] takes me out to [their] house. I look forward to that". When appropriate people were given the freedom to access the community and meet up with friends either on their own or with the support of a member of staff, if needed.

People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing. One person showed us their room and proudly pointed out a painting on a shelf, which they had painted during an art session at the home.

Information regarding confidentiality formed a key part of the induction training for all care staff. Confidential information, such as care records was only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

At our last inspection, in February 2016, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people did not always receive personalised care and care plans were not always up to date and reflective of people's current needs. At this inspection, we found action had been taken. There was no longer a breach of this regulation and people were receiving personalised care.

People told us and indicated they felt the staff were responsive to their needs. One person said, "If I don't feel well they [staff] look after me". Another person told us they could tell staff when they needed extra help and the staff "are there to help me". The health professionals who provided feedback told us staff were responsive to the changing needs of the people they supported. One health professional told us how the support provided by staff at the home had helped one of their clients to improve to a point where they no longer needed the health professional's input. They told us, "[Our client] was being well supported by the staff team and there was no longer a role for their our [specialist support]".

Those people with a limited ability to verbally communicate with staff, were able to demonstrate their understanding of what they were being asked and could make their wishes known. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

People received care and treatment that was personalised and met their needs. People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. Examples of this included: 'I like my tablets offered to me in a pot so I can take them myself' and 'Make suggestions "Shall we do this…?" rather than ask "Do you want to do this… ?' Their care plans also included specific individual information to ensure medical needs were responded to in a timely way. However, where staff had completed a body map for a person due to an injury or concern, there were no records to show that staff had monitored the injury to ensure it was being managed effectively. We raised this with the registered manager and they took action to resolve this. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs.

People's daily records of care were detailed, up to date and showed care was being provided in accordance with people's needs. They included information about the person's behaviours and any participation in activities. When there had been a behavioural incident involving a person, this was recorded and analysed. This allowed the registered manager to identify whether there were any specific triggers to the behaviour and the success of the intervention strategies. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required when they became anxious and displayed behaviours that staff or other people using the

service may find distressing. This corresponded to information within the person's care plan. During the inspection we observed a member of staff supporting this person, who had become anxious, in line with their care plan. Handover meetings were held at the start of every shift and 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.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. One person told us, "[Named member of staff] is my keyworker". Another person said, "We have a keyworker [named their keyworker] they help me; they are lovely".

People were provided with appropriate mental and physical stimulation. People had access to activities that were important to them. Some of the people in the home were able to access the community on their own, while others were encouraged to go out with members of staff. One person told us "I go to computer club". We saw this was linked to a personal achievement goal in their care plan. They also said, "I go out on my own to do my shopping and get the bits I need. Tuesday I go out to the hall and do recreation and on Thursday I go to the disco at Ryde". They added "I like reading my books and watch TV in the evening but like reading my books in the daytime". Another person told us they were part of a theatre group and enjoyed being part of the shows. They also said, "I've been to agricultural college and learned how to look after plants and watering them". They told us they were responsible for looking after the flowers in the garden. They showed us the garden and proudly pointed out the flowers they were growing. A third person said, "I like watching Sherlock Holmes and Heartbeat [on the TV]". The added "I like making things".

During the inspection we observed a drama activity session, which included 'guess the popstar', singing and dancing. Eight of the people in the home were engaged in the activities and appeared to be enjoying themselves. On other occasions we saw staff engaging with people on an individual basis, playing dominoes, painting their fingernails; and involving people in conversation about the activity they were engaged in and the person's interests. One member of staff told us, "I like the fact that you can sit down with them [people] and have a cup of tea with them. It is quite nice that way".

People were actively encouraged to develop their life skills with the opportunity to participate in daily domestic activities, such as laundry, setting tables at meal times, clearing them away and washing up, keeping their bedrooms clean and making drinks for themselves and other people in the home. One health professional provided positive feedback in respect of how staff had supported a person to be involved in activities. They told us, "[Named person] was being supported within the home to engage with activities and was taking pleasure in helping other residents by, for example, making drinks. The staff team were also supporting my client to access the community regularly, and engage in activities that she had chosen to do". A member of staff said, "There are plenty of activities here. They [people] go out a lot as a lot of them are independent. They have people come in to do 60's or 70's music or we go out to places like the donkey sanctuary or a disco". They added, "They [people] are going on holiday to [a holiday camp] or to [another holiday location] it is very good here like that". During the inspection we observed a person engaging with the registered manager excitedly asking the registered manager what things they should take with them for their holiday.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People had access to advocates who were available to support them if they were unhappy about the service provided. The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or

during telephone contact. They also held 'house meetings' which were held every two or three months. We looked at the minutes of the latest meeting, which included discussions regarding the menu, fire safety and plans for their latest holiday.

The provider also sought formal feedback about the home through the use of quality assurance questionnaire, which was sent out to people, their families and professionals. There was an easy read version of the questionnaire available for people, if they required it. The registered manager told us that people were offered the support of a person from a healthcare monitoring organisation to sit with them while they completed the survey. The registered manager provided analysis of the feedback as a way of monitoring the quality of the service provided. We looked at the results of the last survey from October 2016 which were positive. Where issues were raised these were actioned. For example, one person had raised in their survey that they wanted to move to a new home on the mainland. An advocate was arranged and following a meeting with the person and the advocate the move was agreed. Comments from the families free text section included 'Excellent' and 'Very happy with how you care for [my relative]. It puts my mind at rest knowing [they] are well looked after'.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. This was also available in an easy read style should people want to access it. People were initially supported by their keyworker if they had any concerns but had access to an independent advocate if they needed one. One person told us they had an advocate and they knew where they lived if they needed them. All of the people we spoke with told us they did not have any complaints. The registered manager told us they recorded all concerns raised by people as a complaint. We saw that there had been six complaints over the previous year and each of these had been investigated in line with the provider's policy and the outcome fed back to the original complainant.

Good

Is the service well-led?

Our findings

People told us and indicated that they felt the service was well-led. One person said, "[The registered manager] is nice she comes and talks to you". Another person told us, "[The registered manager] is lovely; not been here long; she is very nice. She comes round and chats to you. She asks if we are happy and what we are doing". We observed a number of positive interactions between the people and the registered manager. People appeared relaxed and comfortable when speaking with the registered manager throughout the home or entering their office to ask questions, seek support or engage in a conversation. The health professionals who provided feedback told us they felt the home was well led. One health professional told us, "I feel it's responsive to the needs of the residents and is well led". A member of staff said the home, "is well led with lots of seniors in place; [the registered manager] does listen and there is plenty of staff, which is good".

There was a clear management structure, which consisted of the directors, a divisional manager which was a new post, the registered manager, the head of care 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, "[The registered manager] and [the head of care] are very supportive, I had a health problem and they worked the rota around to allow me to get to my appointments". They added "I like it here; I don't dread coming to work". Another member of staff said, "I definitely feel well supported by management; probably one of the best places I have worked at for that". A third member of staff told us, "[The registered manager] is supportive; they come upstairs and work with us".

The directors of the company were fully engaged in running the service and their vision and values were built around empowering people while promoting their life skills and independence. Staff were aware of the provider's vision and values and how they related to their work. One member of staff told us, "We help people work towards their goals and try and keep them as independent as possible". Another member of staff said, "It is very good here; they [people] have day to day life skills on their [activities] planner as well because they like that". They added "I would recommend the home to people, I love it here".

Regular staff meetings provided the opportunity for the registered 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, "We have staff meetings; they are good; they take a note of what you are saying and action it as well. You feel it is okay to raise things". Another member of staff said, "You do feel you are listened to. They will give your ideas a go and if it doesn't work it doesn't work". A third member of staff told us, "I really do feel supported by the management. I actually do feel involved in the running of the home". They added "I am always pitching ideas to [the registered manager] and she will agree or tell me why she thinks it wouldn't work". They then gave an example of an idea that had been accepted and actioned, which was to put staff pictures on a notice board so people knew who was working. We saw this notice board during our

inspection and observed people referring to it when asking who would be working on the afternoon shift.

The registered manager had an open door policy for the people, families and staff to enabled and encouraged open communication. People told us and indicated they were given the opportunity to provide feedback about the culture and development of the service. People all said or indicated that they were happy with the service provided. A member of staff said, "I love it here [the registered manager] has been really good, supportive. So has [the head of care]; they take a lot of pressure off of us". Another member of staff told us, "[The registered manager] is very approachable. Sometimes I need a chat and she is very accommodating". They added "We are a good team here".

The providers had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager confirmed that support was available to them from the providers. There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The registered manager provided a written monthly feedback report to the provider which included positive stories which were brief updates on people; staffing situation; resident/clinical concerns; and property management. The directors of the company also visited the home on a regular basis to meet with the registered manager and carry out an informal review of the home. Where areas of concern were identified the registered manager prepared an action plan and this formed part of the discussions during their regular meetings. The provider had also created a new post of divisional manager who will be responsible for providing quality assurance oversight.

The registered manager was the quality assurance lead for the home and they carried out regular audits which included infection control, the cleanliness of the home, medicine management, bedrooms, care plans and health and safety. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. The registered manager and the head of care also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

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.

The providers and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) 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.