Ryde House Homes Ltd

Newton Lodge

Inspection report

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Date of inspection visit:
11 July 2017

Date of publication:
15 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Newton Lodge is a privately run care home registered to provide accommodation for up to 14 people living with a learning disability. At the time of our inspection there were 13 people living in the home. The inspection was unannounced and was carried out on 11 July 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.

Staff sought consent from people before providing care. However, People's ability to make decisions was not always assessed in line with legislation designed to protect people's rights. The provider had taken action to address this but at the time of the inspection this was not fully embedded into the home.

People told us and indicated they felt the home was safe. 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.

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 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.

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, choices and 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 encouraged 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 that they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. The provider was 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.

Staff were aware of the risks relating to people and how to manage them. The registered manager had assessed individual risks to people and the environment.

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

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

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

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought consent from people before providing care. However, People's ability to make decisions was not always assessed in line with legislation designed to protect their 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 and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

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

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.

Newton Lodge

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 11 July 2017 by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and 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 11 people using the service and the family of one of the people living at the home. We observed care and support being delivered in communal areas of the home. We spoke with six members of the staff, the deputy manager and the registered manager.

We looked at care plans and associated records for four people using the service, staff duty records and other records related to the running of the service, such as, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel very safe because there are staff here all day and all night". Another person told us, "I am happy. They [staff] are good and look after me". Two other people told us they were able to go out into the community on their own. They said they felt safe because staff knew when they went out and where they were going. One said, "I can go out on the bus by myself on the routes I know".

People were supported by staff who were aware of the individual risks relating to people while providing care and support to them. Staff also understood how to manage those risks effectively to support people to be safe while helping them to retain their independence and avoid unnecessary restrictions. The registered manager had assessed the risks associated with providing care and support to people, which reflected people's individual needs. For example one person had a risk assessment in place to inform staff how to support the person if they became physically aggressive within the home.

The registered manager had also identified risks relating to the environment and the running of the home. These included fire safety, infection control and accessing the kitchen. They had taken action to minimise the likelihood of harm in the least restrictive way. There was a clear record made of when an incident or accident had occurred. These were recorded on the provider's electronic system, which enabled the registered manager to review all incidents, accidents and 'near misses'. The system also provided the opportunity for the provider to carry out analysis across all of their services and provided the opportunity for organisational learning and risk identification.

People received their medicines safely, from staff who had completed the appropriate training and had their competency to administer medicines checked. The registered manager had identified a single member of staff to be responsible for oversight and management of the medicines within the home and they had developed their own quality assurance process and management systems to ensure people received their medicines safely and at the right time. 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 had a MAR 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 daily checks of the MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistakes were found, to ensure people were protected. Staff engaged with people to check that they were happy to take their medicine. Staff supporting people to take their medicines did so in a safe and respectful and unhurried way. One person told us staff supported them to, "take my medications and I don't have seizures now". Another person said, "I always get my medication and if I get constipated they give me something to help with that".

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.

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 of the staff we spoke with were able to explain the actions they would take if they had a concern about people's safety. They were aware of the provider's policy and the other organisations they could report concerns to, such as the local authority and the Care Quality Commission. One member of staff said, "If I had a safeguarding concern I would go to [the registered manager]. If it was about [the registered manager] I would go to CQC". A senior member of staff told us, "If I had to deal with a safeguarding I would speak to [the registered manager] if they were not there I would speak to the staff involved and then seek advice".

People told us that there were sufficient staff to meet their needs. They said that if and when they needed staff, they were able to get help quickly. They also told us staff were available to take them out into the community or shopping when they wanted to go. One person told us, "The staff are good at supporting me for appointments as I get very anxious".

The registered manager told us that staffing levels were based on the needs of the people within the home. We observed that 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. 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 bank staff employed by the provider. One member of staff said, "There is enough staff here. There is sometimes a problem with short notice sickness. They try and cover it with overtime but like everything they phone around but the shift is not always covered". The registered manager told us that they and the deputy manager were available to step in and cover if they were needed.

The provider had a service wide recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's human resource team in conjunction with the registered manager for the home. 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. Following national media coverage in respect of fire related risks, the provider had carried out a review of their fire safety procedures and risk assessment. As a result of the review, actions were identified in respect of a lack of appropriate fire safety signage, which was obtained and installed. 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 (PEEP) 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. People's PEEPs were reviewed after each fire drill to ensure they were up to date.

Requires Improvement

Is the service effective?

Our findings

People told us they felt the service was effective and that staff understood their needs and had the skills to meet them. They said the staff were all trained to look after them effectively. One person added the staff, "keep an eye on me and check I am okay". A family member told us, "I am very happy about how [my relative] is looked after. I am happy that all [their] needs are met".

People's ability to make decisions was not always 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.

Although staff and the registered manager had received training in respect of the MCA and were able to demonstrate an awareness of the principles, they were not always able to apply these to the people they supported. For example, the care plan for one person identified that '[Named person] has limited capacity about decisions in her life' and '[named person] didn't understand when asked if staff could check for symptoms'. However, no assessment of capacity had been completed to allow staff to understand which particular decisions the person was able to make for themselves and which decisions they needed help to make. The provider had already identified that this was an area for improvement and had recently introduce a new consent, capacity assessment and best interest decision making form, 'My life, My choice' to support the registered manager and staff. We saw this form was starting to be used but it had not been fully embedded in the home at the time of the inspection.

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 and the registered manager were following the necessary requirements. Three people had DoLS authorisations in place and DoLS applications had been made for a further five people. 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, such as an independent mental capacity advocate (IMCA), 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. Throughout the inspection we observed staff checking with people that they were happy before they provided support and care.

People were supported by staff who had received an effective induction into their role. Each member of staff

had undertaken an induction programme which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. One member of staff told us, "The induction was very good training; fantastic. I felt confident [when I completed my induction] and I am learning all the time".

The provider had an electronic system to record the training that staff had completed and to identify when training needed to be repeated. The provider had an electronic system for monitoring compliance with their expected training schedule. Registered managers are required to achieve a compliance of 95%, as one of their performance indicators. At the time of they had achieved a 98% compliance rate.

The training available to staff included essential training, such as medicines awareness, safeguarding adults, food hygiene, moving and handling and infection control. Staff were also supported to access specific training to support their role including: pressure injury awareness, autism awareness, dementia awareness, Mental Capacity Act and PROACT SCIP training, which provided staff with a positive range of options for crisis intervention and prevention when supporting people who occasionally displayed behaviour that staff or other people may find distressing. Staff were offered training in a variety for formats to meet their individual learning styles and subject matter. These included practical face to face workshops and individualised E-learning.

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervisions provide an opportunity for 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, "Yes, I have supervisions. They are definitely a two way process". Another member of staff said, "We have lots of supervisions and active supervisions where [the manager or a senior member of staff] pop in to watch you".

People said that they were happy with the food at the home. They told us they were offered choices at lunch time and there was a second choice for dinner. There was a menu on the board in the dining room but it was hand written on the board and was not easy to read for some people.

Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. People had a choice of what they wanted to eat and where they wanted to eat their meal. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences, and offered people support where appropriate. People were encouraged to actively participate in the preparation or their food or collecting their meal from the kitchen.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person told us, "They [staff] are all really good to me and nothing is too much trouble". Another person said, "The staff here are never miserable". A third person told us they formed a good relationship with staff, "but sometimes they leave which upsets me". Other comments about the staff included, "Staff are nice here", "There is a nice atmosphere", "lovely", "good" and "I like them [staff]".

People were cared for with dignity and respect. Staff spoke with people 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. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care. This included making sure doors and curtains were closed and people were covered as much as possible. A member of staff explained the action they took to respect peoples' privacy and dignity, "I have a quiet word with [people] and suggest we go to their room [if they need support with personal care]. I knock on their door and try to make things as private as possible for them".

Staff understood the importance of respecting people's choice. 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. A member of staff said, "I give [people] a choice. I ask them if they want a bath or a shower, which they would prefer. Some want their hair washed, it's up to them. It is their choice and they will tell us".

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.

People were encouraged to be as independent as possible and to develop life skills. During the inspection we observed staff support one person, who used a wheelchair to mobilise and was attempting to leave the dining area when he became stuck. The member of staff identified he was having difficulty and asked him if he needed assistance. He said "Yes" and they helped him to become unstuck, checked he was okay and then encouraged him to continue to mobilise by himself. Another person's care plan stated, 'I will make my own packed lunch' and we saw staff encouraging them to do so. A different person's care plan provided information to staff to encourage the person to regularly brush their own teeth. During the inspection we overheard a member of staff quietly checking with the person as to whether they had brushed their teeth.

People were supported to maintain friendships and important relationships; their care records included details of their 'informal support network', which identified people who are important to the person. All of

the people we spoke with talked about how their relatives visited sometimes and that they went out or home with them. A family member told us they were able to visit their relative whenever they wanted. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of the induction training for all care staff. Confidential information, such as care records were kept securely and 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

People told us they were happy with how staff looked after them. One person said, "Every day the staff ask me how I am first thing in the morning as I can be depressed some days". Another person told us, "I need more help with personal care since I fell and broke my ankle". Other people told us that they did not eat much in between meals because staff were supporting them to 'watch their weight'.

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. Each person's care plan contained a 'communication passport' which provided information to staff on their preferences and how they communicated their moods, such as when they felt happy, sad, angry or anxious. 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. Each care plan had an 'easy read' document supported with widgets, which explained the purpose of the care plan and the information it contained. Widgets are symbols designed to help people with a learning disability understand what had been written. Staff were knowledgeable about people's 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 include: 'Please offer me food and drink as I will not tell you when I am hungry and thirsty' or for a different person 'I will try and make my own drink' and 'I am able to complete my own personal care in the evenings'. People's daily records of care were detailed, up to date and showed care was being provided in accordance with people's needs.

Staff were able to describe the care and support required by individual people. For example, one member of staff was able to describe the support a person required when the person became anxious and distressed. This corresponded to information within the person's 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. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs. In addition, the keyworker carried out a monthly review with the person, of any health changes, activities they had undertaken and activities they wanted to engage in during the next month. One member of staff told us, "I am [named person's] keyworker which means I make sure she has plenty of toiletries, take her shopping, help her with her clothes and make sure her room is nice and tidy". Another member of staff, said, "I do monthly reviews with [named person]. We look at issues and concerns; whether they need anything or what they want to do next month. I do their

personal shopping and I am the point of contact for their family".

People were provided with appropriate mental and physical stimulation. People were supported to access activities that were important to them and were encouraged to access the community. One person said, "I like to go out to local car boot sales and I can walk out to them on my own". Another person told us, "I am supported to do gardening at the house and I also go to a gardening day service. I also like to go to the shops and out to cafes". Other comments from people included "I love going out to my quiz club", "I like going to my Zumba classes" and "I am waiting to go out to Wednesday Group which I like". People were also supported to engage in other activities, such as at a day centre run by the provider called 'Willow Village'. Where people did not want to be involved in activities this was respected. One person told us, "I like to keep myself to myself". Another person told us they had not wanted to go to the day centre on the day of our inspection but had wanted to have a 'lie in' instead. Staff had respected this choice and supported the person when they wanted to get up. People were actively encouraged to develop and maintain their life skills with the opportunity to participate in daily domestic activities, such as laundry, setting tables at meal times, clearing them away and loading the dishwasher, keeping their bedrooms clean and making drinks for themselves. One person told us, "I like to help with hoovering and tidying the house and emptying the dishwasher".

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 resident 'house meetings' which were held on a monthly basis. One person told us, "I go to the residents meetings" and "They ask us about our rooms and I said that I would like a night light, which they are going to sort out for me". We looked at the minutes of the latest meeting, which had taken place in May 2017 and included discussions about precautions to take in hot weather, group activities, the annual holiday and a section called 'round the house' which provided an opportunity for people to raise issues in respect of the home. For example, we saw people had requested a replacement sofa. The registered manager showed us the provider's electronic system where a new sofa had been requested.

The provider also sought formal feedback about the home through the use of a quality assurance questionnaire, which was sent out to people, their families, professionals and staff. The registered manager told us the results from the survey were uploaded to the provider's computer system, which provided an opportunity to analyse the results from the home, and in the context of all of the provider's services. We looked at the results of the last survey from 2016 which were all positive. Comments from people using the service included, 'Like new staff' 'Like going out with staff', 'More movie nights' and 'Curry is nice'. The registered manager told us the provider was arranging for the 2017 survey to be sent out later in the year.

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 included an 'easy read' version supported by widgets for people who preferred their information in that style. People were initially supported by their keyworker if they had any concerns but had access to an independent advocate if they needed one. All of the people we spoke with told us they knew how to complain but did not have any complaints. The registered manager told us they had not received any formal complaints over the previous year. They said they had received two concerns from people using the service about another person at the home. We looked at these concerns and saw that the registered manager had followed the provider's complaints procedure when dealing with them. The registered manager had also recently started a 'dissatisfaction folder' to record minor issues which were dealt with straight away. They

were able to explain the action that would be taken to investigate a formal complaint if one was received.

Good

Is the service well-led?

Our findings

People told us that they felt the service was well-led. There was a clear management structure, which consisted of the directors of the company, Chief Executive Officer (CEO) who was the provider's representative, the registered manager, the deputy manager 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 or concerns with them, which they acted upon. One member of staff told us, "I feel supported by the management. There is an open door policy. The manager never says no. If you have a problem they will deal with it".

The provider was fully engaged in running the service through the CEO and their vision and values were built around providing individualised care, recognising everyone as the individual that they are. Staff were aware of the provider's vision and values and how they related to their work. One member of staff told us, "I like working here. The clients are lovely; the staff are good. I like helping them [new members of staff] get to know [people]". Another member of staff said, "I like it here. It is very friendly. There are ups and downs but that is just part of the work". All of the staff we spoke with said they would recommend the home to their families and friends. One said, "All of the staff and clients are like one big family".

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. 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, "The staff meetings are interactive. They [the registered manager] will look into things and come back to you with feedback". A senior member of staff said, "We have staff meetings and senior meetings. I definitely feel involved in running the home".

The registered manager had an open door policy for the people, families and staff to enable and encourage open communication. People told us they were given the opportunity to provide feedback about the culture and development of the service. People all said they were happy with the service provided.

The provider 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 provider, through the CEO. They told us there were monthly meetings with the provider and the managers from the provider's other services. They could also meet with the provider the CEO, other senior managers and discuss issues and concerns at any time.

The provider had a structured approach to quality assurance and carried out annual audits of the home. They were in the process of enhancing their quality assurance processes across all of their services, which included peer to peer quality assurance inspections involving managers from each of the provider's services inspecting another of their services. They were also developing a quality assurance oversight group, which included the safeguarding lead and the training lead to assess quality across all of the provider's services.

The registered manager had established their own quality assurance checks and audits, which included medicines management, deprivation of liberties (DoLS), infection control, the cleanliness of the home, 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 fire safety, the lift, manual handling equipment and portable appliance testing (PAT). The registered manager also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified these were uploaded to the provider's electronic management system and managed through the regular meeting processes. For example we saw that following a visual audit, the registered manager had raised a concern regarding damaged sealant and woodwork in the downstairs shower.

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 provider 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, which places a duty on staff, the registered manager and the provider to act in an open way when people came to harm.