Ryde House Homes Ltd

Ryde Cottage

Inspection report

Ryde House Drive
Binstead Road
Ryde
Isle Of Wight
PO33 3NF

Tel: 01983614892
Website: www.rydehouse.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ryde Cottage is a privately run care home registered to provide accommodation for up to seven people living with a learning disability. At the time of our inspection there were seven people living in the home. The inspection was unannounced and was carried out on 27 July 2017 and 03 August 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.

The provider's quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service and ensuring the quality of service provision.

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.

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. However, risks to people's health and wellbeing were not always documented. These risk assessments had been updated and documented by the end of the inspection.

People did not always receive care that was personalised and focused on their individual needs.

Records associated with the provision of care and those related to the running of the home were not always accurate and up to date.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the providers' 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.

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 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. 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 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.

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.

Risks relating to people's care and support were not always documented. However, these had been completed by the end of the inspection.

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.

People's ability to make decisions was not always assessed in line with legislation designed to protect people's rights.

Staff sought consent from people before providing care.

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?

Requires Improvement

The service was not always responsive.

People did not always receive care that was personalised and focused on their individual needs.

The provider had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records associated with the provision of care and those related to the running of the home were not always accurate and up to date; the systems in place to monitor the quality and safety of the home were not robust.

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.

Ryde Cottage

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 27 July 2017 and 03 August 2017 by one inspector.

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 four people using the service and two relatives. We observed care and support being delivered in communal areas of the home. We spoke with three members of the staff, the deputy manager and the registered manager. We also received feedback from a care professional.

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.

This service has not previously had a ratings inspection.

Good

Is the service safe?

Our findings

People and their families told us they felt safe. One person said they felt safe because "They [staff] look after me". Another person told us, "I feel safe here". A third person said, "One time I went to Ventnor and got lost. They [staff] were worried about me so they called the police". They added "I found a bus stop and caught a bus to Newport and then I knew how to get home". A different person smiled and tapped their chin to indicate they felt safe. A family member told us, "[My relative] is safe there. When he comes here [family home] to stay he is always happy to go back [to Ryde cottage]". Another family member said, "Yes I feel [my relative] is safe" and added "I don't have to worry". A care professional who provided feedback told us they felt the home was safe and described the support provided by staff for their client and added "We concluded that it was working and much safer for all and more rewarding for the individual".

The registered manager had not always assessed the risks associated with providing care and support to people, which reflected people's individual needs. For example, one person who occasionally displayed behaviour that staff or other people may find distressing, did not have a risk assessment in respect of managing this behaviour when accessing the community. Another person's health file stated they had epilepsy. However, there was no risk assessment to help staff understand the frequency or type of seizures; any triggers or pre-indications; or the action staff should take if a seizure occurred to minimise the risk of harm to the person.

We raised these concerns with the registered manager who ensured that all of the risk assessments were documented and updated to reflected people's current risks before the end of the inspection.

The registered manager had 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 opportunities for the provider to carry out analysis across all of their services and 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. 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 who administered 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 was found, to ensure people were protected. Staff supporting people to take their medicines did so in a safe, respectful and unhurried way. They engaged with people to seek consent and check that they were happy to take their medicine. We observed a member of staff supporting a person with their eye drops. Initially the person refused to have the eye drops. The member of staff accepted

this and left the person. The member of staff returned after a short break and patiently chatted with the person until they were ready to allow them to administer the eye drops.

There were suitable systems and arrangements in place to ensure the safe storage and disposal of medicines; including 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. The registered manager and all of the staff we spoke with had received appropriate training in safeguarding and 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 told us if they had any concerns they would "Go to the manager" and "If they didn't do anything I would take it higher".

All safeguarding incidents were recorded electronically and overseen by the provider's safeguarding lead. The safeguarding lead carried out an internal analysis of all safeguarding incidents, across all of the provider's services and produced a quarterly report. This report identified patterns and trends which were fed back to the provider and the training manager.

People told us that there were sufficient staff to meet their needs. They said that staff were always there if they needed them. They also told us staff were available to take them out to activities, the community or shopping when they wanted to go. A family member said, "There always seems to be enough staff there. When we phone they answer quickly". The registered manager told us that staffing levels were based on the needs of the people within the home. We observed that the staffing level in the home provided an opportunity for staff to engage with people 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, "I feel there is enough staff to cater for the needs of the clients, which is good". Another member of staff told us, "We have enough staff when everyone is here". 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. 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.

Requires Improvement

Is the service effective?

Our findings

People and their families told us they felt the service was effective; that staff understood their needs and had the skills to meet them. They said, the staff were all trained to look after them effectively. A family member told us, "[My relative] has been there a long time. They [staff] really understand [my relative]". Another family member said, "They [staff] look after [my relative] very well. I am sure they understand [their] needs. If a difficult situation arises they get it sorted out". A care professional who provided feedback told us, "Both [the deputy manager and the senior member of staff] were very knowledgeable about the client and had a genuine drive to support [the person] in as best way possible".

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 MCA and were able to demonstrate an awareness of the principles they did not always able to apply this to the people they supported. All of the people at the home were living with a learning disability and had a limited capacity to understand particular decisions. However, no assessment of capacity had been completed to allow staff to understand what 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. All of the people at the home, except one, had DoLS authorisations in place or an application had been made. 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.

The provider had an electronic system to record the training that staff had completed and to identify when training needed to be repeated. The system also monitored compliance with their expected training schedule. Registered managers were required to achieve a compliance of 95%, as one of their performance indicators. At the time of our inspection the registered manager had achieved the bench mark of 95% compliance rate.

The training available to staff included the provider's mandatory 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. Staff also received PROACT SCIP training. This training provided staff with a positive range of options for crisis intervention and prevention when supporting people who occasionally behaved in a way 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. One member of staff told us, "I have access to training if I want it. I can apply on line for E-learning or if I am required to do it then they can book me straight on". They added "Training is fun. My favourite is the autism awareness. You see a video on how autism affects people it is very interactive. It has helped me realise I need to talk slowly. It is all about how you communicate; try and see it from their perspective about how they feel". Another member of staff said, "I am up to date with my training; our own in-house trainer is really good and we can do E-learning as well".

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 the management team to meet with staff, feedback on their performance. It also provided an opportunity to 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 they found the supervisions "Help me if I am doing something wrong or not doing something. They keep things fresh in your mind. You can raise concerns during your supervision if you want to. [For example] if you notice someone's personal care is not being done properly. They do listen and will do something about it". Another member of staff said, "My supervisions are reasonably regular. I have three or four a year. I can request more if I want. I feel well supported".

People said that they were happy with the food at the home. They told us they were offered choices at lunchtime and there was a second choice for dinner. One person told us, "The food is really good; you can choose what you want. I make my own drink, when I want one". 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. A member of staff told us the menu was chosen by people during the 'house meeting' and if people didn't like what was on the menu they were offered a choice. We observed a member of staff engaging with a person at lunchtime, patiently explaining the different choices available to them for their evening meal.

People chose when and where they ate their meal. During lunchtime a person said they had chosen a "Corned beef sandwich" for their lunch, which they ate sat at the dining table. Another person had a cheese sandwich, which they ate sitting in the lounge. A third person had been provided with a packed lunch as they were going out over the lunchtime period. When they returned they told us they had enjoyed their

lunch.

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, "I like it here. It is comfortable and quiet. Staff are nice". Another person nodded their head, smiled and tapped their chin to indicate they liked the staff who supported them. Other comments from people included, "Nice staff; I am happy [here]" and "I like them [the staff]". A family member told us, "Staff are very caring and patient with [my relative]. They understand how they should look after him". Another family member said, "I think the staff are very very good. I can only praise everything they do. Staff are excellent very caring I can't fault them". They added "They [staff] couldn't be anymore decent than they are".

People were cared for with dignity and respect. A family member told us, "They treat [my relative] with respect. They would soon let them know if [they] were not happy". 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. One person told us, "They [staff] knock on my door and say hello". Another person said, "Yes, they knock on my door". A family member told us, "[my relative] always keeps [their] door shut. Staff respect that and knock before they go in which is good". 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.

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, where they sat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. One person's care plan stated 'I like to make choices and will touch/point to what I want. Offer me a choice of two or three things at a time no more'. During the inspection we observed staff offering the person a choice of what they wanted to drink and what sandwich they wanted, in line with their care plan.

People and where appropriate, their families were involved in discussions about developing their care plans. One person told us, "Yes, I think we talk about it [care plan] sometimes". A family member told us, "My daughter comes over with me and we review [my relative's] care. We are included in any decisions they make". They added "[My relative] is included as well in [their] care reviews". 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. One person was supported to attend Willow Village, which is a project on the provider's site providing meaningful and fun activities for people living with learning disabilities, these activities included, gardening and up cycling. On the morning of our inspection, the person told us they were getting ready to go to work [at willow village] and when they returned later in the afternoon they said they had been busy and expressed a sense of achievement. Other people were encouraged to make their own drinks or carry them through to where they

wanted to sit. Another person's care plan stated, 'Put the toothpaste on their brush and encourage them to brush their teeth themselves".

People were supported to maintain friendships and important relationships; their care records included details of their 'informal support network', which identified people who were 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. One person pointed out another person in the home saying "That lady in the garden is my friend". A family member told us they were able to visit their relative whenever they wanted. They said, "I usually visit once a month but I know I can visit anytime". Another family member said, "[My relative] comes home for a weekend every month".

People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing. One person showed us their bedroom which was painted in a very bright colour. They told us, "I picked the colour; I really like it". Their room was full of knick-knacks they had brought while they had been out shopping. They said, "I am going to have a sort out and take stuff to the charity shop".

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.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and treatment that was personalised and met their needs. For example, one person was not being supported to follow their religious belief when they were at the home. We raised this with the deputy manager who accepted this was an area for improvement and undertook to ensure their religious needs were met. The same person was also allergic to particular types of medicines; however, there was no information available in the care records as to how the allergy affected them or the action staff should take if they had an allergic reaction. Another person was allergic to bee stings, however there was no information in their care plan to help staff understand how a sting would affect them and the action to take if the person was stung. A third person's care records stated there was a need to reduce their caffeine intake. However, it did not give a starting point or identify how much it needed to be reduced by. A different person's medicine record, in respect of an 'as required' (PRN) medicine, stated they should 'take one when required for agitation or anxiety'. However, it did not identify how that person would display anxiety or alternative strategies to try before using the medicine.

We raised these concerns with the registered manager who took immediate action to update their care records.

People and their families told us they were happy with how staff looked after them. One person said, "They [staff] look after me". A family member told us, "[My relative] needs regular visits to a hospital [at a location off of the island]. They always send someone with [my relative] so [they] don't get anxious". Another family member said, "I can't praise them enough; they seem to be able to cope with [my relative] and try their best to do the things she wants to do". A care professional who provided feedback told us, "Through working with the home and a behaviour specialist we worked out a strategy and better way to manage [my client's] behaviour". They added, "The home demonstrated their commitment to the resident when they had an eye operation and they supported him through his stay in hospital, the home also clearly had a positive relationship with the family and kept them up dated".

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'. This 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.

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. For example, one person's care plan detailed the names they used when referring to their mother and father. 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 they were eating their meals. 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. This was supported by a correspondence book which provided written information about people's care for those staff who were not working at that time.

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. This review included any health changes, activities they had undertaken and activities they wanted to engage in during the next month. One person told us, "[Name person] is my keyworker he talks to me about what I am doing". A member of staff explained their role as a keyworker and added, "I do her monthly care plan and support [them] like a kind of advocate if [they] have any complaints".

People were provided with appropriate mental and physical stimulation. People were supported and encouraged to access the community and activities that were important to them. One person said, "I can go out when I want. I just let them know where I am going. Today I went to Newport on the bus. I have a key so I can come in when I want". Another person told us, they regularly attended Willow Village. A third person said they were, "Going out to [named shop] with [named member of staff] to buy things". People were also supported to engage in other activities, such as visiting a day centre in the community, swimming, arts and craft, disco, 'Willow Village' and trips out to places of interest, shops and out for meals. Where people did not want to be involved in activities this was respected. One person did not want to take part in arts and crafts as a group activity. Staff respected this and arranged for them to have one to one support to do arts and craft by themselves. People were actively encouraged to develop and maintain their life skills with the opportunity to participate in daily domestic activities, such as, clearing crockery away and loading the dishwasher, keeping their bedrooms and the house clean and making drinks for themselves. One person told us, "I need to tidy my room; it is messy; need to sort it out".

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. A family member said, "I have no complaints but if I did I would speak to [deputy manager]". Another family member told us, "We know how to complain but we have nothing to complain about". The registered manager told us they had not received any formal complaints over the previous year. They were able to explain the action that would be taken to investigate a formal complaint if one was received.

Requires Improvement

Is the service well-led?

Our findings

The records associated with the provision of care and those related to the running of the home were not always accurate and up to date. For example, we reviewed the weekly medication audit for one person and found five occasion when the figures recorded were inaccurate. We also identified concerns regarding risk assessments and care records already identified during this report. We raised these concerns with the registered manager who took action to ensure all records were accurate and up to date.

Both the provider and the registered manager had a structured approach to quality assurance to monitor the quality and safety of the service provided. However, this approach was not robust and did not identify the concerns we found during the inspection. We raised this concern with the registered manager and the accepted it was an area for development. They told us the provider was in the process of enhancing their quality assurance processes across all of their services. This included peer to peer quality assurance inspections involving managers from each of the provider's services inspecting another of their services. A peer to peer audit of Ryde Cottage was booked for the end of August 2017. The provider carried out an annual audit across all aspects of the home. A report and action plan was prepared following this audit and this was managed by the provider through the regular meeting process with the registered manager. 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 were managed through the deputy manager and included a medicine audit, food safety audit, bedding audit, care plans, health and safety audit, and cleanliness and infection control. There was also a system of audits in place to ensure that safety checks were made in respect of fire safety, and water temperatures. The registered manager 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.

People and their families told us that they felt the service was well-led. One person said, "[The deputy manager] is okay; I would tell him or [the senior] if I was unhappy". One family member told us, "Definitely well led. The manager and deputy manager are friendly and approachable". Another family member said, "The manager is very efficient. [My relative] is happy here; they keep us up to date with what is happening. I would recommend the home". A care professional who provided feedback told us they did not have any concerns regarding the leadership of the home.

There was a clear management structure, which consisted of the chief executive officer (CEO) who is the provider's representative, the registered manager who also held some provider level responsibilities, a deputy manager who oversaw the day to day running of the home and a senior care staff member. Staff were confident in their role and understood the part each staff member played in delivering the owners' vision of high quality care.

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, "It is lovely working here; the residents are lovely, down to earth; calm not hectic; staff do cater for people's needs". All of the staff we spoke with said they would recommend the home to their families and friends.

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, "I have been to two staff meetings. Both the [deputy manager] and the [registered manager] were there and have a good listening ear, which is good". Another member of staff said, "I am very comfortable raising things at the [staff] meetings. [The registered manager] and [deputy manager] are easy to talk to".

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.
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 family member told us, "They are always asking me if I am happy or have any questions". Another family member said, "They always ask if I am happy [with the care my relative is receiving]".

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. The registered manager told us the provider was arranging for the 2017 survey to be sent out later in the year.

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 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.