

Marran Ltd

# Arran House

## Inspection report

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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?	Requires Improvement ●

# Summary of findings

## Overall summary

This inspection took place on 25 November 2016 and was unannounced which meant the registered provider and staff did not know we would be visiting.

Arran House is a mid-terraced property situated in the centre of Guisborough. The service provides residential care and accommodation for up to four people who have learning disabilities and mental health needs. It is situated close of local bus route and within walking distance to local amenities and the centre of Guisborough. At the time of inspection there were three people using the service.

The service had a registered manager who had been registered with us in respect of the registered provider's new registration since 8 January 2015. Before this they were registered as manager for the registered provider's previous registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our last inspection, we found that people who used the service and others were not protected against the risks of inappropriate or unsafe care and treatment, as effective quality assurance processes were not in place to enable the registered manager to identify and minimise these risks. We asked the registered provider to take action to ensure they were meeting the regulations.

At this inspection people told us they felt safe. Risk assessments were in place for people who needed these. Some risk assessments lacked detail around specific medical conditions. However, staff were knowledgeable about the associated risks and action they should take.

Accidents and incidents were monitored to identify any patterns and appropriate actions were taken to reduce the risks. The registered manager reviewed all accidents and incidents on a monthly basis. Falls were also monitored to identify any trends occurring.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place and the registered provider had a policy in place to minimise the risk of abuse occurring. Safeguarding alerts had been submitted to the local authority when needed and appropriate action had been taken.

Emergency procedures were in place for staff to follow. A robust procedure for recording fire drills had been implemented, which recorded how each person had managed during the evacuation process.

Medicines were managed appropriately. The registered provider had policies and procedures in place to ensure that medicines were handled safely. Medication administration records were completed fully to show when medicines had been administered and disposed of. People we spoke with confirmed they

received their medicines when they needed them and we observed this happening safely.

Certificates were in place to ensure the safety of the service and the equipment. Maintenance and fire checks had been carried out regularly.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed. Only one new staff member had joined the service in the past 12 months. An induction process had been completed with the registered provider.

Staff performance was monitored and recorded through a regular system of supervisions and appraisal. Staff had received training to support them to carry out their roles safely and training was up to date. People who used the service suffered from a variety of medical conditions including diabetes, epilepsy and learning disabilities. However, we did not see evidence of any specialist training in these areas.

People were supported to maintain their health and make independent decisions regarding food and fluid, including participating in creating a weekly shopping list. People spoke positively about the nutrition and hydration provided at the service. Staff understood the procedures they needed to follow if people became at risk of malnutrition or dehydration and records showed appropriate action had been taken to make these referrals when needed.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew what action they would take if they suspected a person lacked capacity. However, appropriate documentation was not always in place to support best interest decisions. We have made a recommendation about this in the body of our report.

Each person was involved with a range of health professionals and this had been documented within each person's care records. From speaking with staff we could see that they had a good relationship with health professionals involved in people's care. People's care records contained evidence of appropriate referrals to professionals such as dieticians and dentists.

The service was clean and pleasantly decorated throughout. People were able to bring their own furniture and personalise their bedrooms as they wished. People had been involved in decisions about the décor and furniture in the service.

People spoke highly of the service and the staff. People said they were treated with dignity and respect and observations throughout the inspection evidenced this.

People were actively involved in care planning and decision making. This was evident in signed care plans, consent forms and from observations during the inspection. Information on advocacy was available and displayed throughout the service.

Care plans detailed people's needs, wishes and preferences. However some care plans lacked person-centred and relevant information. Care plans were reviewed every 12 months, but staff told us this would be done sooner if there were any changes that needed to be recorded.

We saw people participating in a range of activities and people were able to independently choose which activities they wanted to do. Some people could independently access the community and we saw this person coming and going throughout the day of inspection. People were able to tell us about the activities they did on a weekly basis and told us they enjoyed the activities provided.

The service had a clear process for handling complaints. There had been no complaint received in the past twelve months, but the registered manager told us they regularly ensured people knew how to make a complaint. A copy of the complaint policy was displayed in the home and on peoples bedroom doors in easy read format . People we spoke with confirmed they knew how to make a complaint.

Staff told us they enjoyed working at the service and felt supported by the management. Staff told us they were confident any concerns would be dealt with appropriately. We could see from our observations and speaking with people that the registered manager had a visible presence at the service and people were familiar with them.

Quality assurance processes were in place and regular audits were carried out by the registered manager and care manager, to monitor the quality of the service. However, these audits did not always identify areas of concern with regards to care plans not containing sufficient person-centred information.

Feedback was sought from people who used the service. Feedback questionnaires had been sent to people in February 2016. The registered manager told us this information was evaluated and action plans produced if needed. All the feedback from the questionnaires had been positive. People were given the opportunity to provide feedback during regular 'resident' meetings and a feedback box was also located at the service.

The service worked with various healthcare and social care agencies and sought professional advice to ensure that the individual needs of people were being met.

The registered manager understood their role and responsibilities and was able to describe when they would be required to submit notifications to CQC.

## 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

Some risk assessments lacked detail around specific medical conditions. However, staff were knowledgeable about the associated risks and action they should take.

Staff we spoke with understood the procedure they needed to follow if they suspected abuse might be taking place. Alerts had been raised when required.

A safe recruitment process was followed to reduce the risk of unsuitable staff being employed.

Medicines were managed appropriately. The registered provider had policies and procedures in place to ensure that medicines were handled safely.

### Is the service effective?

Good ●

The service was effective

Staff performance was monitored and recorded through a regular system of supervisions and appraisal.

Staff received training to support them to carry out their roles safely and training had been refreshed when required.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to maintain their health. People spoke positively about the nutrition and hydration provided at the service.

### Is the service caring?

Good ●

The service was caring

People spoke highly of the staff and said they were treated with dignity and respect.

Staff were knowledgeable about the likes, dislikes and preferences of people who used the service.

Care and support was individualised to meet people's needs.

### Is the service responsive?

Good ●

The service was responsive

People were actively involved in care planning and decision making.

People told us about the range of activities on offer and told us they enjoyed the activities provided.

The registered provider had a clear process for handling complaints. People we spoke with confirmed they knew how to make a complaint

### Is the service well-led?

Requires Improvement ●

The service was not always well-led

Quality assurance processes were in place and audits were regularly carried out to monitor the quality of the service but they did not always identify areas of concern.

Feedback from people who used the service, relatives and staff was sought.

Regular staff meetings had taken place and staff told us they were supported and included in the running of the service.

# Arran House

## Detailed findings

### Background to this inspection

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

This inspection took place on 25 November 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, we reviewed all of the information we held about the service which included notification submitted to CQC by the registered provider. We spoke with the responsible commissioning officer from the local authority commissioning team about the service. We also contacted the safeguarding team at the local authority and two other health and social care professionals to gain their views of the service.

The registered provider had completed a provider information return (PIR.) This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan for the inspection.

During the inspection, we spoke with all three people who used the service and spent time observing staff interactions with people. We looked at all communal areas of the home, including the lounge, kitchen, dining area, bathrooms and peoples bedrooms, with their permission. We spoke with the two staff members on duty and the registered manager.

We did not use the Short Observational Framework for Inspection (SOFI) during this inspection as we felt it was not appropriate in such a small service where people could talk with us and such observations would be intrusive. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Instead we used general observations of people's care and support throughout our visit.

During the inspection we reviewed a range of records. This included two people's care records, including care planning documentation and medication records. We also looked at four staff files, including staff

recruitment, supervisions, appraisals and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the registered provider.



# Is the service safe?

## Our findings

We asked people if they felt safe living at the service. People we spoke with confirmed they felt safe. One person said, "Yes, I do feel safe, but it can sometimes be too quiet. I do like it here and I love [staff member]. They are my favourite." Other comments included, "I like it. I like the staff."

During our last inspection, in February 2015 we found there were no formal risk assessments in the care files we looked at, even where staff had worked with people positively to take risks and gain increased independence. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at arrangements for managing risk to ensure people were protected from harm. Risk assessments were in place for people who needed these in areas such as falls, medication, heat exhaustion and evacuation in the event of a fire. Risk assessments were specific to people's care needs. For example, one person needed fluids restricting due to a medical condition and a risk assessment was in place.

Staff were extremely knowledgeable about people's needs, the associated risks and what action they would need to take to reduce risks. People were supported with a regular team of staff who were aware of their current needs and had been employed by the service for a long period of time.

We looked at arrangements in place for managing accidents and incidents and what actions were taken to prevent the risk of reoccurrence. Records were in place to show that accidents and incidents were reviewed on a monthly basis by the registered manager who checked to see if there were any repeated patterns of accidents or incidents. Appropriate forms were completed for each accident or incident that had occurred. We spoke with staff that were knowledgeable about what action they would take if a person was suffering regular accidents, such as making a referral to other professionals such as the falls team.

Personal emergency evacuation plans (PEEPs) were not in place for all the people who used the service. PEEPs provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. We spoke with the registered manager about this. They told us that they judged PEEPs to be unnecessary as people who used the service were able to evacuate safely, independently, and that regular fire drills took place to ensure they followed the correct procedure. Records confirmed that regular fire drills had taken place and included people who used the service. Individual risk assessments were also in place. One to one fire drills had taken place to ensure people were fully compliant with the evacuations procedure as part of the risk assessment.

Risk assessments were in place associated with the day to day running of the service. Regular checks were made by the maintenance staff in areas such as water temperature, emergency lighting and fire alarms and the service was in a good state of repair. Required test certificates in areas such as electrical testing, gas servicing and firefighting equipment were in place.

All staff we spoke with had a good level of knowledge and understanding of safeguarding and the different types of abuse. They were able to tell us procedures they would follow should they suspect abuse. An up to date safeguarding policy was available and safeguarding information was displayed on notice boards throughout the service. We looked at training records in relation to safeguarding training and could see that all staff had received training in this area.

We looked at records relating to safeguarding. We could see that referrals had been made to the local authority when required and the registered manager had often contacted the local authority safeguarding team for advice to ensure safeguarding considerations were logged appropriately.

Staff told us they would not hesitate to whistle blow (tell someone) regarding any concerns they had. One staff member told us, "I would not hesitate to report anything to my manager. I know it would be dealt with in confidence." Another staff member told us, "All staff here would whistle blow and I would have no problem doing it if I had concerns. We are a small team who work here and we all want the best for these people."

Systems were in place for the safe management of medicines. People's use of medicines was recorded using medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. All of the MARs we looked at contained a current photo of the person. A photo helps staff to ensure they are administering medicines to the right person.

We reviewed two people's MARs and saw there were no gaps in administration. A list of staff signatures for those staff administering medicines was stored in the front of the MARs. This helped create a clear record of who was administering medicines. The home had a medication policy in place, which staff understood and followed.

Medicines were stored securely. Room temperatures were monitored and recorded daily. At the time of our inspection, there was no medication being administered that required storage in a medical fridge but the service had one available should this be required.

Stock checks of medicines were carried out every month to ensure people always had access to the medicines that they needed. Surplus medicines were securely stored until they could be returned to the pharmacist for safe disposal. There were no people who used the service prescribed controlled drugs. These come under the Misuse of Drugs Legislation and have strict control over administration and storage. We could see that there was secure storage and appropriate means of recording controlled drugs administered should this be required.

We looked at arrangements for ensuring safe staffing levels. We were shown a copy of the staffing rota, which was displayed on a notice board in the service. The rota showed that there was a small team of four staff who provided support to people. During the day there were two staff members on duty and during the night there was one staff member to provide support to three people. The number of staff on the rotas was sufficient to meet the needs of people who used the service. Staff told us that extra support could be provided when needed, for example if a person was going on an outing or on holiday. During the inspection we could see that there were enough staff on duty to support people with chosen activities. One person was able to access the community independently and staffing levels meant that the other two people who used the service could access the community with the staff on duty when they wished. One staff member told us, "We have a stable team of staff who have been here years and know people very well. We all work as a team." Another staff member told us, "We don't have problems with staffing really. There is always enough

staff on duty and staff from the registered providers other locations provide cover for holidays and things like that if it is needed."

During the inspection we looked at one staff file relating to recruitment. We only looked at one record because the service had a stable team of staff who had started employment many years ago with only one new staff member commencing employment in the past 12 months. We could see from the records we looked at that safe recruitment procedures were followed. An applications and interview questions had been completed. Two checked references and a Disclosure and Barring Service (DBS) check had been sought prior to the member of staff starting employment at the service. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people from working with children and vulnerable adults.

Communal areas and bathrooms were clean and tidy. Cleaning equipment was securely stored when not in use. Throughout the day we saw staff cleaning communal areas and bathrooms. People who used the service were encouraged to help with these tasks and one person told us how they, "enjoyed cleaning and keeping their room tidy." Another person told us how they had helped with the hoovering on the morning of inspection.

# Is the service effective?

## Our findings

We asked staff to tell us about their induction, training and development opportunities they had been given at the service. Staff told us, "We do have training when it is needed. I feel I have the training I need to do my job correctly." Another staff member told us, "I did an induction when I first started. I did a few full days of training. It covered lots of things."

During the inspection, we looked at four staff files relating to training. We could see that staff had received training in areas such as safeguarding, first aid, moving and handling, health and safety, medication, first aid, food hygiene and infection control. Training in these areas had been refreshed in 2014 and 2015. We could not see any specialist training that had taken place, for example in mental health, learning disabilities or diabetes. Given the specialist nature of the service we would expect staff to have received training in these areas. During our last inspection in February 2015, the registered manager had told us that plans were in place for staff to receive such specialist training through group supervisions. The supervision records we looked at confirmed that a session had taken place in July 2016 and discussed 'personality disorders' but the supervision form completed provided little information as to what was discussed. Other group discussions that had taken place included risk assessments and positive risk taking. We discussed the lack of specialist training with staff who told us they had worked previously in similar environments and had extensive experience of working with people who had mental health needs and learning disabilities. The registered manager told us that specialist training would be added to the training plan for 2017.

People we spoke with told us they thought staff were suitably trained to look after them. One person told us, "Yes, staff are good. They know what to do."

Staff were supported with regular supervision and appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. From the records we looked at, we could see that these meetings were used to discuss any support needs the staff member had, as well as confirming their knowledge and performance over a period of time. Records confirmed regular supervisions and appraisals were taking place and staff told us they felt supported by management.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. 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 and hospitals 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.

During our last inspection in February 2015 we raised concerns that people who potentially lacked capacity

to consent to care being provided had not been assessed or best interest decisions made using the MCA. At this inspection, we could see that improvements had been made and the care plans we looked at documented when decisions had been made in people's best interest and that other professionals had been involved.

However, there was no documentation in care plans to support these decisions, such as copies of the MCA assessments or the options that had been considered with regards to a person's best interest. One care plan, dated April 2016, detailed that a person needed support to access the bank to withdraw funds but they needed advising on 'what was an appropriate amount to withdraw' and that they had been assessed as 'lacking capacity to manage finances independently'. There was no evidence of the MCA assessment that had taken place. We were later told that this person now had their monies managed by the local authority estates department but the information in the care plan had not been updated. We spoke with staff who were aware of this and the person knew they collected their money each week and the amount. Following the inspection the registered provider told us that this was a recent change and documentation was going to be updated to reflect this.

Staff demonstrated an understanding of the Mental Capacity Act 2005 and were able to explain what action they would take if they suspected a person lacked capacity.

The person who was subject to a DoLS authorisation understood that they were unable to access the community on their own and required staff to take them out. There was no copy of the DoLS authorisation available on the day of inspection. The registered manager told us an application had been submitted to the local authority but they were not sure if they had received the authorisation. A copy of the application that had been submitted was not available at the time of the inspection. They explained that the local authority generally contacted the registered provider via telephone to inform them of any authorisation and that there was usually a delay with the actual form being submitted to them. This meant the registered provider could not ensure any conditions on a DoLS authorisation were being met as they had not received copies of the authorisation. Following the inspection the registered manager told us they had contacted the local authority to ask for a copy of the DoLS authorisation.

We recommend that the registered provider seek advice and guidance from a reputable source, about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the recording of best interest decisions.

Staff had a good understanding with respect to people's choices and consent. We could see that consent to care had been given by people and signed documentation was present in care plans to evidence this. Throughout the inspection people were encouraged to make independent decisions with regards to everyday tasks.

People were supported to maintain a balanced diet. People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). People's weights were monitored in accordance with the frequency determined by the MUST score, to determine if there was any incidence of weight loss or gain. This information was used to update risk assessments and make referrals to relevant health professionals if needed. Staff were able to tell us whether the people they supported had specific dietary needs and if so what they were.

There was no set menu plan at the service. As this was a small service, people would often discuss what they would like at meal times and 'vote' on the choices with the majority of votes deciding the meal that would be prepared with help from staff. On the day of inspection, people who used the service had decided they wanted 'chip shop' for lunch. They were able to select what they wanted and this was collected by one person

at lunch-time. At tea time, they had chosen poached egg, bacon and tomatoes with toast. One person expressed she would prefer a fried egg with their meal. The staff member kindly explain that a poached egg was a healthier option, but if they would prefer a fried egg that could be accommodated.

People had allocated cupboard space in the kitchen where they could store food items they had chosen to buy. People created a weekly shopping list with the support of staff. We spoke with staff with regards to meals and they told us, "People can have what they want to eat and we just try and steer them in the right direction with regards to healthier options. One person really likes to drink coke so we try and encourage them to limit the amount they have." Food that people had eaten was recorded on a weekly planner so all staff could see meals that had been eaten the previous days to avoid repetition.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, social workers, dentists, mental health specialists and dieticians. We could see that referrals to these professionals had been made in a timely manner and these visits were recorded in people's care records.

We looked at arrangements that were in place to ensure that the design and adaptation of the service's premises met the needs of people receiving care. Arran House is a mid-terrace property and provides accommodation over three floors. The premises are intended to provide the three people living there as much of an 'ordinary' environment as possible. The service was clean and pleasantly decorated throughout. The building was in a state of good repair and people told us they had input into the décor of the home. People's bedrooms were personalised and we observed people and staff discussing ideas for additional items in their bedrooms. People had space to store personal belonging such as perfumes, deodorant and clothes. People we spoke with were very happy with their personal space and that they could adapt it as they wished. The service had been adapted to accommodate people who could not use the stairs, with a bedroom and bathroom located on the ground floor and ramp access via the back of the property. At the time of the inspection, there was one person who was unable to use the stairs. Their needs were being fully met because of the adaptations that had been made.

# Is the service caring?

## Our findings

People who used the service told us they were very happy and staff were caring. One person said, "I love [staff member], they are my favourite, but I do like them all." Another person told us, "Yes, they are all really good. They help me." Another person told us about a recent visit to a local theatre to watch an Elvis impersonator. They expressed how happy they were that they were able to go and how grateful they were to the staff saying, "I danced away most of the night and [staff member] did too. It made my year."

We saw staff were respectful and called people by their preferred names. Staff were patient with people when speaking with them and took time to ensure people understood what was being said. People often asked questions around what staff thought about their ideas and plans for the day. Staff encouraged people to make their own decisions and often replied with, "What would you like to do today", which encourage people to make their own decisions. It was clear that staff knew people well. Staff were caring and attentive. We saw that staff monitored the time people had spent in their room and after a certain timescale would go to check on them.

We looked at the arrangements in place to support people with positive risk taking and to maintain their independence. During our visit we observed people being encouraged to help with normal household tasks where they were able. These tasks included hoovering, clearing pots away and helping with meal preparation such as setting the dining table. Staff told us about one person who had been supported to gain independence. The person accessed the community independently, but was reluctant to go into shops where they may need to ask for assistance, such as a shoe shop. The staff member explained that they had accompanied the person to Teesside Park to purchase some shoes. The staff member had waited outside the shop so if the person began to panic the staff member would be available to assist. The person managed this task independently and proudly showed us the shoes they had purchased.

We looked at the arrangements in place to ensure equality and diversity and if support was given to people in maintaining relationships. People who used the service told us they had been supported to maintain relationships that were important to them. For example, one person told us about their boyfriend and how they visited them and showed us a bunch of flowers that had been delivered displayed in the lounge area. People also told us how they had regular visitors to the home, such as family and friends. Another person told us how they had continued to attend their church on Sundays after moving into the service, because this was important to them. Staff were fully aware of the person's religion and how important this was to them.

People who used the service told us their privacy and dignity was respected. One person said, "I can go to my room when I want and staff knock before entering. They always ask me before doing anything." Staff explained to us how they respected people's privacy and dignity, such as keeping curtains and doors closed when assisting with personal care and by respecting people's choices and decisions. One person's care plan detailed that they should be left to shower or bathe alone and the staff member should wait outside the bathroom in case the person shouted and required assistance. We saw staff seeking permission before any care was provided to people and people we spoke with confirmed this.

Care plans detailed people's wishes and preferences around the care that was provided. We could see evidence, such as signatures in care plans, that showed people were involved in planning their care. People were aware of their care plans and what information was contained in them. One person recognised their photograph on a file we looked at during inspection and told us, "That is me. You are looking at my file all about me, what I like and what I don't." The person was happy for the information to be looked at.

It was evident from discussions with staff and the registered manager that all staff knew people well, including their personal history, preferences and like and dislikes. One staff member said, "These people are like family to me. I like to think I know them all inside out. I have been here years now." Another staff member told us how they had originally started work as 'bank' staff, but applied for a full time position as they enjoyed the work, people and wanted to work at the service on a permanent basis.

People who used the service had access to independent advocates. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The registered manager told us that people had used advocates in the past and information was available and displayed on a notice board in the kitchen of the service. Staff were aware of the process and action to take should an advocate be needed.



## Is the service responsive?

### Our findings

During the inspection we looked at two care files. Care files contained personal information such as people's likes, dislikes and life history. Care files also contained care plans which were produced to meet individual's support needs in areas such as communication, mobility, personal care, nutrition, finances and medication. Some of these were detailed and focused on the person's preferences. For example, one care plan detailed that the person preferred to have a shower every morning and only wanted female staff to support with this. Another care plan detailed how a person should be encouraged to dress independently and although they would often put shoes on the wrong feet, they should only be advised of the error and independently correct this for themselves.

However, some of the care plans we looked at were not up to date. For example, one person had their finances managed by the local authority estates department, but their care plan had not been updated with this information. The registered provider told us this was a recent change and the care plan would be updated. Some care plans lacked person centred information. For example, we were told during inspection that one person had recently lost a close friend and this had impacted on their mental health and emotional needs. This information was not documented in their care plan. We were contacted by the registered provider following the inspection and informed that a professional meeting was being held to discuss the person's change in mental health and that the care plan would be updated following the outcome of this meeting.

Some care records contain incorrect information. For example information recorded in a person's care file indicated that this person had a 'feelings diary' and that they should be encouraged to write in this daily or if they were feeling 'down'. We could see that this information had not been incorporated into their 'emotions' care plan. Following the inspection the registered provider told us the feelings diary was not an active document and was no longer used by the person and the reason it was not detailed in the person's emotions care plan.

When people had a specific care need, plans were not always in place to ensure they received person-centred support. For example, one person was diabetic, but no care plan had been developed around this. Diabetes had been covered in the nutritional care plan, but the information was very basic and did not provide sufficient details for staff to be able to provide person-centred support. Another document contained in the care file detailed how a person had incontinence issues and had 'hidden clothes and put dirty clothes back into draws'. This was not covered in any of the care plans in the care file.

We have addressed the issues with some shortfalls in record keeping in the Well-Led domain.

Staff were extremely knowledgeable about the care that people received. Although information was not always recorded in people's care files, staff gave detailed information around each person's care needs and how they were managed. Staff were responsive to the needs of people who used the service and this was clear through observations completed during the inspection. One person told us, "They are all great. I don't know what I would do without them. They take me out and I love it"

People were supported to access activities which they enjoyed. Staffing levels at the service meant that people could be supported with daily activities. During the inspection we spent time observing staff and people who used the service. We saw one person who had done some craft activities that day and proudly showed everyone the cards they had made. Staff praised the person and it was clear this had a positive impact on the person's mood. Another person had painted their nails on the day of inspection with assistance from staff. One person accessed the community independently and we saw this person coming and going throughout the day. Staff always asked where the person was going and how long the person thought they would be, so they could ensure they knew the person's whereabouts at all times.

People told us about day trips and holidays they had been on with staff at the service. These included a holiday to Butlins, trips to the theatre, Blackpool and Disney on ice. At the time of our inspection, staff on duty were in the process of booking a trip to the theatre to see a Christmas pantomime, which people were looking forward to. Another person was planning a shopping trip to a local Christmas market and staff were helping the person make a 'present list'. Time was scheduled daily so people could access the community if they chose to do so. Activity schedules were displayed in people's care files, which showed that people often attended walking groups and visited the registered provider's other services, which were also in Guisborough, to participate in activities such as parties and other entertainment.

We asked people who used the service about activities on offer. People told us they enjoyed 'getting out and about' and that they 'loved going out with the staff'. They told us they enjoyed visiting the registered provider's other service and meeting other people.

We were given a copy of the registered provider's complaints procedure. The procedure gave people details about who to contact should they wish to make a complaint and timescales for actions. The registered manager told us that they spoke with people on a daily basis so people who used the service would generally express any concerns they had to them and this was encouraged by management. They also explained that they had meetings every three months with residents and this provided an opportunity for people to voice any concerns. This meeting was also used to ensure people knew how to voice a concern or make a complaint, with the process being explained to people regularly. The meetings were attended by a staff member that people were familiar with, but that did not work with the people directly. The registered manager explained they felt this would make people feel more comfortable raising a concern if they needed to. An 'honesty feedback box' had also been introduced to the service so people could raise a concern by writing it down and posting it in the box.

We looked at the record of complaints. No complaints had been received in the past 12 months. People we spoke with confirmed they knew how to make a complaint and could provide a name of the person they would report this to.

## Is the service well-led?

### Our findings

The registered provider was Miltoun House Group, which became a limited company and re-registered as Marran Ltd on 31 December 2014. The service has a registered manager, who has been registered with us in respect of the registered provider's new registration since 8 January 2015. Before this they were registered as manager for the service's previous registration. The registered manager of Arran House was also the registered manager of three other services in the local area and spent their time between these services. The registered manager was supported by a home manager at Arran House.

The registered manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services, ensuring they provide people with good services and meet the appropriate quality standards and legal obligations. Six monthly audits were carried out by the registered manager in areas such as medication, care plans, finances, catering and housekeeping. The home manager then completed 12 monthly audit checks covering the same areas. From the records we looked at, we could see action plans had been developed, where issues had been identified, to ensure remedial action was taken. For example, a fire door was identified as 'sticking' and not closing correctly. The registered manager had taken action and contacted a professional to correct the issue and this action was recorded.

However, these audits were not always an effective monitoring systems. The quality audits completed by the registered manager and home manager had failed to identify that care plans had not been updated when changes occurred and did not provide sufficient detail in some areas. Care records did not always contain person-centred information and although staff were knowledgeable about people's needs this was not always documented.

People who used the service spoke positively about the registered manager and told us they were "caring" and "[Registered manager] is lovely." We could see the registered manager had a visible presence at the service and regularly interacted with people, relatives and staff. People who used the service were confident in approaching the registered manager and we saw positive interactions during the inspection.

We asked staff about the management of the service. All staff we spoke with confirmed they were supported by management. One staff member told us, "[Registered manager] is a great manager. I have never had any reason to complain and the home runs smoothly." Another staff member told us, "I have worked in other homes and this one is different. The manager is approachable and I for one feel listened to. [Registered manager] knows we know these people better than anyone."

The registered manager had a clear vision of the culture of the service and told us about the improvements they planned to make to the auditing tool in 2017, which included ensuring all care plans were reviewed by the registered manager every 12 months and that would include meetings and discussions with key workers. They also told us how they had more specialised training planned for 2017.

Regular staff meetings had taken place, with the most recent in September 2016. Meeting were arranged for care staff, home manager and the registered providers. Minutes of the meeting showed that staff were given the opportunity to share their views and management used the meeting to keep staff updated with any changes within the service. From the records we looked at, we could see that these meeting were well attended by staff.

The home manager of the service also completed a weekly feedback sheet which highlighted any issues found in that current week. This was then given to the registered manager to review and update. The weekly feedback sheets also recorded any staff issues, planned supervisions, accidents, safeguarding concerns and any new care plans that needed developing.

The registered providers were kept updated about the day to day running of the business by the registered manager and we were told they were 'actively involved'. Monthly meetings were also arranged to discuss the registered provider's locations.

Questionnaires had been distributed to people who used the service and completed in February 2016. All the feedback provided was positive. The registered manager told us that although they distributed questionnaires they also arrange three monthly meetings with people to gain their views.

The registered manager understood their roles and responsibilities and was able to describe the notifications they were required to make to CQC. Safeguarding alerts had been submitted to the local authority when required.

We looked at the culture of the service, including if it was open, transparent and accountable. Throughout our inspection the registered manager and staff were open and cooperative, answering questions and providing the information and documentation we asked for. They were keen to act upon feedback provided to improve the service.