Ryde House Homes Ltd

Ryde House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ryde House is a privately run residential home which provides accommodation and support for up to 64 people, who have a learning disability or an autistic spectrum disorder. The home was split into five separate units; the main building, Ryde House, and four separate purpose built buildings; Maple Tree, Sycamore house, Beech House and Silver Birch. Each unit was run as an independent home within the grounds of Ryde House, with their own staff team. The provider is currently reviewing their registration, in line with the best practice guidance 'Registering the Right Support' for people with a learning disability, with a view to registering each unit separately.

This inspection, which was unannounced, took place on 24 and 25 May 2017 and 1 June 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 registered manager for Ryde House was also one of the directors and the manager for the Silver Birch unit.

However, the fact that one of the directors held different roles at different levels within the organisation with overlapping responsibilities created a lack of clarity, clear accountability and a lack clarity regarding responsibilities.

Staff across all of the units 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, although the managers of three of the units had assessed individual risks to people, in the units Silver Birch and Beech House we found that risks were not always identified and managed effectively.

Staff across all of the units were responsive to people's needs. However, although care plans in most of the units were personalised and focused on individual needs and preferences, this was not always the case in Silver Birch or Sycamore House units.

There were effective systems in place in four of the units to monitor the quality and safety of the service provided. However, in the Silver Birch unit the systems we less formal and less robust.

Staff across all of the units sought consent from people before providing care and staff followed legislation designed to protect people's rights and freedom.

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

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

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

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

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary, in a patient and friendly manner.

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

In each unit 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 and their families told us they felt their unit was well-led and were positive about their unit manager who understood the responsibilities of their role. The provider was fully engaged in running the home and provided regular support to the unit managers. 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 service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service, which is split into five units, was not always safe.

The managers in three of the units had assessed individual risks to people and taken action to minimise the likelihood of harm in the least restrictive way. However, in two units we found that risks were not always identified and managed effectively.

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

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

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

Is the service effective?

Good

The service was effective.

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

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 important relationships and be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were responsive to people's needs. However, although care plans in most of the units were personalised and focused on individual needs and preferences, this was not always the case in two units..

People were encouraged to take part in activities that were important to them.

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

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of clarity at senior level because one of the directors held multiple roles at different levels within the organisation at the same time.

There were systems in place in four of the units to monitor the quality and safety of the service provided. However, in the other unit the systems were less formal and less robust.

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

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

Ryde House

Detailed findings

Background to this inspection

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

This inspection, which was unannounced, took place on 24 and 25 May 2017 and 1 June 2017. The inspection team consisted of two inspectors, a specialist advisor in the care of people with learning disabilities and autism, and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

Ryde House provides accommodation and support for up to 64 people, who have a learning disability or an autistic spectrum disorder. It was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore, Beech House and Silver Birch. Each unit was run as an independent home within the grounds of Ryde House, with their own staff team.

We spoke with a total of 18 people using the service, some of these people were able to speak with us in a way that was more limited due to their communication needs, seven family members and one family friend. We observed care and support being delivered in the communal areas of the each of the units. We spoke with the chief executive officer, who was the provider's representative; the registered manager, who is also one of the directors of the service; four unit managers, the deputy managers at each of the units and 15 members of staff. We also spoke with three health professionals and received feedback about the service from eight other health and social care professionals.

We looked at care plans and associated records for 14 people using the service and records relating to the

management of the service. These included staff duty rota records, staff recruitment files, records of complaints, accidents and incidents, policies and procedures, and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in January 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that people were not protected from the risk of infection because infection control risk assessments were not regularly carried out. At this inspection, we found action had been taken. There was no longer a breach of this regulation and the home was clean, well maintained and appropriate risk assessments in respect of infection control had been completed.

People across all of the units told us they felt safe. One person said "I feel very safe here' and 'all of my dolls and toys are kept safe". They told us that if they needed help or support from someone "they come straightaway". Another person told us "Staff are there [if they needed them]". A third person said, "Safe, yes safe" and smiled to indicate they were happy. Family members told us they did not have any concerns over the safety of their relatives. One family member said, "I am happy to know that when I go home [my relative] is content and happy. I know she is safe". Another family member told us, "This is like another home [from home] for [my relative] I feel he is very safe here". A third family member said they felt, "very assured that [my relative] is safe". They added "I am confident that staff are available for [my relative] when he needs them".

All of the health and social care professionals we spoke with or provided feedback told us they felt that the people in each of the units were safe. One health professional said, "I have no concerns at all". Another health professional who regularly visited each of the units told us, "I never have any concerns about anyone's safety". A care professional told us in their feedback that they 'found the service to be safe, although the young people I work with do have behaviours that can put themselves and others at risk. I have found that [the unit staff] manage this well and have developed positive risk assessments and care plans to ensure that the staff team are aware of the risks and respond in a way that reduces them'.

People were supported by staff who knew them and understood the risks related to their care. They were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. For example, one staff member was able to explain the risks relating to one of the people they supported when they were travelling in a vehicle. Another member of staff, from a different unit, was able to describe the risks relating to a person when they supported them to mobilise safely.

The manager for each unit was responsible for assessing the risks associated with providing care to each individual within their unit. These were recorded along with the actions identified to reduce those risks. However, we found that in the Silver Birch unit not all risks relating to people's care had been identified and managed effectively. For example, one person, who was living with dementia, spent long periods of time being cared for in bed; however, they did not have access to a call bell or other means of alerting staff if they needed urgent assistance. We raised this with the manager of the unit, who was also the registered manager and they told us that staff were allocated to support this person and they would check on him regularly. However, these wellbeing checks were not recorded and the manager was not able to demonstrate that they had taken place. The person was also supported to mobilise using a hoist and, although there was a risk assessment related to the use of the hoist, this did not include the fact that they suffered with osteoporosis, which meant they were at additional risk when being hoisted. We raised this with the manager

who agreed it should have been included as part of the risk assessment.

In the Beech House unit we found that one person, who was being supported to access the community, required medicines that were subject to additional controls by law. However, there were no risk assessments in place in respect of safe transportation and management of these medicines away from the unit.

We raised these concerns regarding risk assessments with the registered manager and the Chief Executive Officer (CEO) who accepted this was an area for improvement and undertook to take action to rectify these concerns as part of their ongoing improvement action plan.

In all of the other units, individual risks to people were managed effectively and people were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person who occasionally displayed behaviour that staff or other people may find distressing had a risk assessment in place to enable them to go swimming or access the community. A social care professional who provided feedback told us, 'I have found that Ryde House [unit staff] manage this [risk to people] well and have developed positive risk assessments and care plans to ensure that the staff team are aware of the risks and respond in a way that reduces them'.

The manager of each unit had also identified risks relating to the environment and the running of the unit. These included risks relating to the use of; cleaning materials (Control of Substances Hazardous to Health – COSHH); the kitchen; electrical equipment such as TVs; radiators and hot water. Windows were reinforced and had window restrictors, if required. The managers had taken action to minimise the likelihood of harm in the least restrictive way.

Where an incident or accident had occurred, there was a clear record of this on the provider's electronic system. This enabled the manager of each unit to review all incidents, accidents and 'near misses'. It also provided an opportunity for the CEO to carry out analysis to identify trends and risks across all of their services, providing the opportunity for organisational learning and risk identification. For example, as a result of a series of historic incidents in the community, the provider had arranged for staff to carry explanatory cards to give to people in the community if an incident occurred. These cards identified the home where the people were from and contact details if they had any concerns regarding what had occurred.

People experienced care in a safe environment because the staff and managers in each of the units had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and managers had received safeguarding training. One member of staff said, "We have done lots of safeguarding training. If I had a concern I would go to my manager". They added "If they didn't do anything about it I would take it higher and speak with [the CEO]". We looked at safeguarding records in each of the units and saw that where concerns had been identified they had been recorded and raised appropriately with the local authority adult safeguarding team. A social care professional who provided feedback told us a person they supported still had episodes where they displayed behaviour that staff or other people using the service may find distressing. They said that when this occurred 'staff appeared to respond appropriately, safeguarding him, other residents and themselves'. All safeguarding incidents were recorded electronically and overseen by the provider's safeguarding lead. They carried out an internal analysis of all safeguarding incidents, across all of the provider's services, providing a quarterly report identifying patterns and trends which were fed back to the provider and the training manager.

People in each of the units were supported by staff who had received medicines training and had had their

competency to administer medicines assessed to ensure their practice was safe. The provider had a clear medicines policy and there were arrangements in place to support people with their medicines. Medicines administration records (MAR) were completed correctly. The MAR chart provided a record of which medicines were prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person's MAR had a sheet with a photograph of the person and information about any allergies. Records showed that people's medicines were consistently available for them. Staff made regular checks of the MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistakes were found, to ensure people were protected. One member of staff told us that following a recent error they had made, they were stopped from administering medicines for a month. They received additional training and were then observed while administering medicines by the deputy manager on three occasions before being able to administer medicines on their own again.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place in each unit to ensure the safe storage and disposal of medicines and suitable arrangements were in place for medicines which needed additional security. A refrigerator was available in each unit 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 were supported to take their medicines in a safe and respectful way. Staff explained the medicine they were giving and sought the person's consent before giving it to them.

People across all of the units and their families told us they felt there were sufficient staff to meet their needs. People required different ratios of staffing to meet their needs, which varied during the day and according to the activities they wanted to take part in. We saw that staff were constantly available to support people when needed but provided the freedom to allow them to be as independent as possible when safe. One family member told us, "There is always plenty of staff around when we visit and I know they take [my relative] out when she wants to go". Another family member said, "There is a number of good staff here. They are always nearby if you need them". All of the health and social care professionals we spoke with and received feedback from told us they did not have any concerns regarding the level of staffing in the units.

Each of the unit managers were responsible for the staffing levels within their units, which they told us was based on the needs of the people they were supporting. For example, one unit had sufficient staff available during the day to allow one person to access the community when they wanted, which required the support of five staff members. The staffing level within the units provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner, in line with their care plan and assessed needs.

Each unit had 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 one of the other units; or from another home owned by the provider. The unit managers and their deputies were also available to provide extra support when appropriate. The provider had a system in place to monitor staff hours across all of their homes to ensure staff were not working excessive hours, which could impact on the safety of people.

The provider had a 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 each unit manager. 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. The staff we spoke with confirmed that they had not been able to start work until all of their checks had been completed. One member of staff told us, "In the interview they went through my application form. I then came in for an active interview with residents and staff to see how I interacted with them before being offered the job".

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 each unit, which contained individual personal emergency evacuation plans that detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency.

Good

Is the service effective?

Our findings

At our last inspection, in January 2016, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff were not following the Mental Capacity Act 2005 (MCA). At this inspection, we found that action had been taken to ensure the provider was compliant with the regulations.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The registered manager and staff had received training in respect of the MCA and were able to demonstrate an awareness of the principles and application of best interest decisions. The provider had also recently introduced a new consent, capacity assessment and best interest decision making process called, 'My life, My choice'. This process provided a clear structure and guidelines to enable staff to continue to support people to make decisions either with their consent or in their best interests.

People told us that staff asked for their consent when they were supporting them. In each of the units we observed staff seeking consent when supporting people. They checked with people that they were happy to speak with us. The manager of one of the units saw that a person was wearing his shoes on the wrong feet. They pointed it out to them and asked if the person wanted to change them over, which they agreed. They then patiently supported the person to change their shoes around.

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. The manager for each unit was responsible for requesting and overseeing the management of any DoLS that had been authorised.

We found the manager of each unit was following the necessary requirements. However, the recording system for DoLS in Silver Birch unit was not robust and staff were not always able to identify when a DoLS authorisation was due to expire. For example we found the DoLS authorisation for one person had expired in June 2016 and no renewal application had been made. We pointed this out to the unit manager, who was also the registered manager, and they took immediate action to ensure the renewal application was made. Staff had been trained in MCA and DoLS; People's families and other representatives had been consulted when decisions about restricting people's liberty were made to ensure that they were made in people's best interests and were the least restrictive option.

People and family members told us they felt the service was effective and that staff understood their needs and had the skills to meet them. One family member said, "Staff know [my relative] very well. His carers are

good at understanding him". They added "Staff have the skills to look after him; they are often on courses and things". Another family member told us, "Things couldn't get any better. Staff are well trained. I couldn't be happier; staff understand [my relative's] foibles". The health and social care professionals we spoke with and who provided feedback told us staff were well trained and understood people's needs. One professional said that staff were, "knowledgeable about the clients. When I ask a question about them, they [staff] know the answer". Another professional who provided feedback described the improvements their client had made since being at their unit. They told us, 'This is very effective work and a great step in [my client's] personal development, in my professional judgement largely down to the environment [my client] lives in and his anxiety levels reducing. This is down to the very effective behaviour management plan, staff getting to know him very well and responding to his anxiety in a positive manner'.

People were supported by staff who had received an effective induction into their role. Each member of staff had undertaken an induction programme which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. One new member of staff told us that, "I had an in-house Induction following my interview where I was shown the care plans, fire procedures and I had to do all my training during my trial period". Another member of staff said they had, "completed my Care Certificate. You have to complete within 3 months but they offered help with this".

The provider had an electronic system to record the training that staff had completed and to identify when training needed to be repeated. The provider's training lead explained the new electronic system, which identified compliance with the expected training schedule, using a red, amber, green alerting system. The requirement for a 95% compliance of staff within the unit was one of the unit manager's performance indicators.

The training available to staff included essential training, such as medicines awareness, safeguarding adults, food hygiene, moving and handling and infection control. Staff were also supported to access specific training to support their role including: Autism awareness, dementia awareness, Mental Capacity Act and PROACT SCIP training. This provides staff with a positive range of options for crisis intervention and prevention when supporting people who occasionally displayed behaviour that staff or other people may find distressing. Staff were offered training in a variety of 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 a lot of training; I have first aid booked for next month. E-learning refreshers you can do at home or at work". Another member of staff said, "The training is brilliant, there is so much training going on here". A third member of staff told us, "I get an email that tells me what I need to do. I prefer e-learning. You can do it at work or if you do it in your own time you get paid for the time". We observed a practical training session on autism where staff were encouraged to experience a role play to help them understand how an autistic person may feel. This included being asked to try to write while wearing gloves and being distracted by loud noises. We saw that this was a positive experience for the staff involved.

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, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by their unit management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us, "We have regular supervisions where we talk about how I feel and about training; anything". Another member of staff said supervisions provided an opportunity for them to "raise more confidential things and ask for more training. I asked to do my NVQ 3 and now I am doing it". A third member of staff told us they had had a positive supervision where they were able to discuss an incident which occurred while

they were supporting a person in the community. They added "Even after it's happened staff and the manager will always ask me if I'm ok".

People across all of the units were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "I like all of the food here. I can get whatever I like to eat or drink. I have help to cut food up if I need it". Another person told us, "The food is good". A third person said, "They have got me eating their foreign food, pasta, but I enjoy it". A different person told us that staff were available at mealtimes when needed.

Each unit provided their own menu which was displayed in a pictorial way to remind people of the choices that were available to them. We saw that several people were provided with a packed lunch prepared by staff prior to them going out for the day. In the Ryde House unit there was a 'snack board' on the wall by the kitchen door, which provided a visual reminder to people as to what snacks were available. People could use this board to indicate what they would like to eat and drink. The board was set up with people's known preferences.

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences, and offered support and encouragement when appropriate. Mealtimes were a social event, with staff and people eating together. Staff were aware of people's needs and engaged with them in a supportive, patient and friendly manner, offering support and encouragement when appropriate. We observed one member of staff supporting a person with their meal after asking the person, "Do you want me to help you cut your food"?

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. One person said, "I see the doctor or dentist when I need to". A health professional told us, "All of the [units] are engaged with the annual health checks, which is good. They are proactive and very responsive to the things I have asked them to do". Another professional said staff in the Sycamore unit were "very responsive in both communication, and in terms of implementing advice".

Good

Is the service caring?

Our findings

Staff across all of the units had developed caring and positive relationships with people. The people we met were happy and relaxed. We asked one person if they liked living at the home and they smiled, giggled and said "Yes". Another person who was just going swimming said "Goodbye, see you later". A third person told us, "I love it here". Family members told us that staff were very caring and supportive of their relatives. One family member said, "This is marvellous here, more than happy". They told us their relative had "been through a stressful transition" and added, "The difference is remarkable, he is happy again and he is singing again". A third family member said, "Sometimes when [my relative] is at home with me, he wants to come back [to the unit] which is the best outcome and gives me confidence". A further family member told us, "They [staff] have always been very thoughtful".

The health professionals we spoke with and provided feedback told us staff were caring and patient when supporting people. One professional told us, "I found that there are some very committed staff at Ryde House who have shown great care and compassion for the people who live there. They have worked well with some very complex people and gone above and beyond in their duty". Another professional said, "Seeing [my client] with staff made the good working relationship evident, where there is banter, which [my client] enjoys and is age-appropriate for him as being a very young adult in a residential setting. The parents have expressed how happy they were with the service and feel like it is [their relative's] home. They feel he thrives in the setting and would like him to continue living there". Other comments from professionals included, "All of the staff seem to be caring in their approach", "The staff team and its manager are very caring and adopt a great approach that is very caring and considerate", "Yes I believe [staff are caring] and I have personally witnessed this myself" and "Staff demonstrated care and patience and I had no concerns of this nature".

People across each of the units were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. We observed positive interactions between staff and people who were only able to communicate verbally in a limited way. Staff spoke with them chatting about what was happening around them. We saw one member of staff support a person to visit an activity in the grounds of the home. When they got there the person changed their mind and wanted to go back to the home. The member of staff patiently engaged with the person talking with them as they supported the person to return to their unit. We observed another member of staff singing to a person who was visibly happy about it. A family member said staff, "treat [my relative] with dignity and respect. They are really good with him. He is always keen to come back here when we take him out".

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. A member of staff said, "People here won't do what they don't want to do. I always knock on their door. We also tell new people in the home to respect people's privacy and knock on doors before coming in". They added, "We have one person who is sight impaired, so you speak softly when you approach her so she knows you are there". The health professionals who provided feedback told us they did not have any concerns regarding how staff respected people's dignity and privacy. One professional told us, "I have no concerns about staff treating people with dignity and

respect".

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected.

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. A member of staff said, "I like the care plans; they tell you everything [about the person] their likes and dislikes and things that you can work with them on". A family member told us, "When [my relative] first came here we went through everything". They added, "I know that all of the staff are very caring. Sometimes I am here and they may not know I am here and I can overhear how they support people".

People were encouraged to be as independent as possible. For example one person who was blind liked to sit in a communal alcove listening to music. The provider had fitted a hand rail from their bedroom to the alcove to allow them to be independent and safely access the alcove whenever they wanted. A family member told us their relative, "helps in the kitchen, butters bread, washes up and maintains her life skills". Another family member told us their relative goes to college three times a week.

People were supported to maintain friendships and important relationships; their care records included details of their 'informal support network', which identified people who are important to the person. One family member told us that their relative "kept a diary every day. I asked staff to continue to write in her diary what she had done, so they have done. It is nice to read what [my relative] has been up to". Family members said they were able to visit at any time and were given the opportunity to speak with their relatives privately.

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

Requires Improvement

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. One family member said, "[My relative] had hay fever, [which impacted on his health conditions] and they [staff] managed it very well for him". Another family member told us, "When the need arises they take action, call a doctor and keep me informed about what is happening. [My relative] has been here [number of years] and they have helped her to become more manageable and calm. They have always been very thoughtful [with how they support my relative]". A third family member said their relative's needs were met in a way that was responsive to his interests, likes and dislikes.

All of the health and care professions we spoke with or provided feedback told us staff were responsive to the changing needs of the people they supported. One professional said, "One resident has bespoke needs and the home have got to know his needs and why he feels safe here. He openly refers to Ryde House as his home". Another professional told us staff had, "carried out a good assessment of my client's needs prior to moving in and I feel they [staff] have been able to meet their [person's] needs and respond appropriately to them". They added staff in a different unit "have always been very responsive to the needs of the residents and have carried out thorough risk assessments and care plans. They have acted quickly when any concerns have been raised and then resolved the problem, ensuring they engage with me, the residents and family members". A third professional said, "The service have always responded very quickly".

In most of the units people received care and treatment that was personalised and met their needs. People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. However, in Silver Birch, although staff were aware of people's needs and how to support them, we found that information in people's care plans was generic and did not focus on people's individual's needs. For example, one person was prescribed 'as required' (PRN) medicine for when they became anxious. Staff were directed to give the PRN medicine when the person became 'unsettled'. However, there was no information in the care plan to help staff understand what 'unsettled' looked like for this person, at what point the PRN medicine should be given or any alternative strategies that could be used to support the person before the medicine was administered. The care plan for a different person, in Silver Birch, who was unable to communicate verbally, stated: 'If in pain you will know from my facial expression'. However, there was no information to help staff understand what the person's facial expression would look like when they were in pain. We raised these concerns with the unit manager, who was also the registered manager, who agreed this was an area for improvement in their unit and undertook to take action to rectify these concerns as part of their ongoing improvement action plan. In Sycamore House unit we found one person's weight was being monitored because they had been assessed as being obese. However, there were no plans in place to help staff support the person and encourage a healthy lifestyle.

Across all of the units, each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. Care plans and

related risk assessments were reviewed monthly to ensure they reflected people's changing needs. In addition, the keyworker carried out a monthly review with the person of any health changes, activities they had undertaken and activities they wanted to engage in during the next month. However, we found that some of the keyworkers in Silver Birch had 'cut and pasted' the same review over a period of months, so they were not accurate and did not reflect the person's current health changes and the activities they had undertaken. We pointed this out to the unit manager and they took immediate action to ensure all keyworker reviews were up to date and accurate.

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

People's daily records of care were detailed, up to date and showed care was being provided in accordance with people's needs. They included information about the person's behaviours and any participation in activities. Staff members were able to describe the care and support required by individual people. For example, one staff member was able to describe the support a person required when they wanted to mobilise and another member of staff was able to explain the support they would give to a person if they became distressed and displayed behaviours that staff or other people using the service may find distressing. 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.

People were provided with appropriate mental and physical stimulation. People had access to activities that were important to them. People were supported to access the community, clubs and day centres. One person told us, "We do lots of activities which I love. I go to the garden centre and out for drives and do lots of things in the house". Another person said, "I like the activities I do". A family member said their relative, "gets out every day for walks which he loves, out in the car for picnics and the library. He has one to one support for all of his activities". Another family member told us their relative enjoyed doing activities around the unit. A third family member told us their relative, "enjoys playing the keyboard in his room". They added staff, "do things with him. He likes riding [in a car] around the island and going swimming".

During the inspection we observed an activity session., Each person was doing an activity they liked; some were doing some colouring; another was being supported to complete a puzzle, whilst another was supported to do some knitting. Each person was supported by a member of staff who supported them with their needs. People also attended various group activities such as a weekly disco, swimming, or college. Each year people who chose to, were supported to participate in a sponsored walk which raised money for charity. Other people were engaged in delivering the local magazine each month in the local area. People who wanted to spend quiet time had access to their own private beach which provided a natural sensory environment for people who wanted to spend 'quiet time'. We observed one person who preferred not to be in the noisy lounge and was in the kitchen having a pamper session whilst listening to her music. Another person was having a private music session out in the garden area whilst supported by a staff member.

People across all of the units 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 also had access to independent advocates who were available to support them if they were unhappy about the service

provided. Each of the unit managers sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. They also held 'house meetings' which were held every two or three months. We looked at the minutes of the latest meeting, which included discussions regarding the menu, fire safety and plans for their latest holiday. As a new initiative, the manager of Maple Tree unit had introduced 'easy read' house meeting minutes supported with widgets. Widgets are symbols designed to help people with a learning disability understand what had been written.

The provider also sought formal feedback about the home through the use of quality assurance questionnaires, which were sent out to people, their families, professionals and staff. The Chief Executive Officer (CEO) told us the latest questionnaire, which was due to be sent out included an 'easy read' version, supported by widgets, if people required it. They 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 provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. This was also provided in an easy read pictorial format if people needed it. 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 did not have any complaints. One person told us they had made a written complaint last year and were happy with how it was dealt with. A family member said they had, "never made a complaint but I am aware how to if necessary". Another family member told us, "I have no complaints". They then gave an example of when they had raised a concern and told us their concern had been taken seriously and the manager of the relevant unit had responded quickly to resolve the concern, which was done to their satisfaction. Each unit manager was responsible for managing their own complaints which were recorded on the provider's electronic system to allow them to have oversight of any concerns and identify any trends or lessons to be learnt.

Requires Improvement

Is the service well-led?

Our findings

People across all of the units and their families told us that they felt the home was well-led. One person said, "I think all of the staff are happy here; I like the Manager". Another person told us, "Yes [the unit was well led], the manager knows me". A family member said their relative's unit was, "definitely well led; good leadership team; [the unit manager] is very well informed and listens to you. She is respected by her staff". They added, "I cannot find fault and would recommend it to my family and friends". Another family member told us the unit where their relative lived was, "very well led, without a doubt. I am completely satisfied with what they do for her". A friend of one of the people said, "[The unit management] are very good; [my friend] enjoys herself; any worries and they are very willing to listen. It is just like a home from home". We observed a number of positive interactions between the people and the managers of each of the units. People appear relaxed and comfortable when speaking with their manager throughout their unit or entering the office to ask questions, seek support or engage in a conversation.

All of the health and care professions we spoke with or provided feedback told us they felt the home was well led. One professional said "The home is well led. It is nice having individual managers in the home units. They know their residents. I think it works well". Another professional told us, "I am extremely happy with the service. Since my service user moved in he has come along so much in such a short period, is learning new skills on a day to day basis and has developed very positive relations with all the staff team". A third professional said, "The manager [of one of the units] is always approachable and easy to talk to about residents. He has engaged well with residents and their families and as far as I am aware, has addressed any staffing concerns when raised. He is open and honest and when I've had any concerns he listens and is willing to work together to resolve them". Other comments from professionals included, "The managers [of a different unit] seem to have the house running smoothly", "I have worked with the managers [from another unit] and have found them to be caring and responsive in their approach", "I feel that the service is well led, show initiative and care. And at present have no concerns", "The manager [of one unit] is professional and works well to ensure a high standard of care is delivered and maintained" and "The manager [at a different unit] has excellent knowledge and skills when working with the young adults with complex needs who live there and is conscientious about ensuring his staff team are doing a good job".

The provider had a system of oversight at an organisational level, which was dynamic and continuing to evolve through the development of a quality assurance oversight group, including the safeguarding lead and the training lead to assess quality across all of the provider's services. They were in the process of enhancing their quality assurance processes across all of their services, which included peer to peer quality assurance inspections involving managers from each of the provider's services inspecting another of their services.

Each of the unit managers was responsible for carrying out quality assurance within their unit. All of the units, with the exception of the Silver Birch unit had a structured approach to quality assurance checks and audits. These included infection control, the cleanliness of the home, medicine management, care plans and health and safety. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. However, Silver Birch unit had a less formal and less robust approach to quality assurance, which meant that concerns and

issues, such as those we found during this inspection where not always identified. We raised this concern with the CEO and the registered manager, who was also the unit manager for Silver Birch and they accepted this was an area for improvement and undertook to take action to rectify these concerns as part of their ongoing improvement action plan.

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore, Beech House and Silver Birch. Although, there was a defined management structure at a strategic level, which consisted of the directors of the company; a senior management team which included, the chief executive officer (CEO) who was the provider's representative, a safeguarding lead, training lead, human resources lead and the registered manager for the home. There was a lack of clarity in respect of the role of one of the directors, who was also the registered manager of the home and the manager of one of the units, Silver Birch. This provided the potential for confusion, with overlapping responsibilities leading to a lack of clear accountability and ownership of issues.

In addition the management structure included the individual unit managers, their deputy managers and senior care staff. Staff in the units were confident in their role of delivering the provider's vision of high quality care. One member of staff said, "We are like a family, when one member of staff is down the others will pick them up". Another member of staff told us, "I have had some health issues myself and I have been very well supported by the company and the team I work in". A third member of staff said, "This is a very welcoming place to work and everything is dealt with effectively".

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 providers' vision and values and how they related to their work. One member of staff told us, "I love it here and the fact that I am responsible for the happiness of the people I support". Another member of staff said, "This is the best job I have ever had. I wouldn't be doing [extra hours] if I wasn't happy here". A third member of staff told us, "A lot of the team are older than me but we all get on well and they are eager to share their knowledge". Staff also told us the provider would support them with crisis loans if they needed them and there was an on-site counsellor and trainer.

The manager of each unit held regular staff meetings which provided an opportunity for the unit manager to engage with staff and reinforce the provider's values and vision. Staff spoke positively about the culture and management of the different units. 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. One staff member said, "Staff meetings are very helpful. If you have issues you can raise it then and it will be resolved. I definitely feel listened to and they will do something about it". They then gave an example of an issue they had raised which was resolved by their unit manager. Staff told us the managers of each unit were approachable and had an open door policy for the people, families and staff to enable and encourage open communication. One member of staff said, "I feel that the home is very transparent and open all round".

People, their families and heath and care professionals told us they were given the opportunity to engage with the management team and provide feedback about the culture and development of the service. People and their families told us they were happy with the service being provided.

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, staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider 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.