Ryde House Homes Ltd

Ryde 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?	Good

Summary of findings

Overall summary

Ryde House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This inspection was unannounced and took place on 10,11 and 13 September 2018. Ryde House provides personal care and accommodation for people with a learning disability and Autism, including people who have behaviours that can place themselves and others at risk.

Ryde House is registered to accommodate up to 64 people. At the time of the inspection there were 55 people living at the service. The service is a group of individual units set within one location. There are five units which are registered as one service, Ryde House (main house), and four separate purpose-built buildings; Maple Tree, Sycamore House, Beech House and Silver Birch. Each unit had their own staff team including unit managers, deputy managers and senior staff. All five units were looked at as part of this inspection.

Since the last inspection in 2017, the provider had reviewed their registration, in line with best practice guidance 'Registering the Right Support' for people with a learning disability. Although, they do not meet the requirement of registering the right support because each unit accommodates more people than Registering the Right Support guidance advises. Nonetheless, the service had been developed and was in line with the values and other aspects that underpin Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

We last inspected the service in May 2017 when we did not identify any breaches of regulation, but rated the service as 'Requires improvement'. At this inspection, we found improvements had been made.

There was a registered manager in place. 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 was supported by a manager in each of the five units.

The registered manager for Ryde House was also one of the directors of the provider's company and the unit manager for Silver Birch unit. At the last inspection in May 2017, we found that the director held different roles at different levels within the organisation with overlapping responsibilities, which created a lack of clarity and clear accountability. At this inspection a review of the management team had taken place and there were two senior managers who were awaiting registration with Care Quality Commission to become the joint registered managers for the service. Following the inspection, their registration was completed. The two senior managers were working to ensure there was a consistent approach across the service, with a clear process for accountability and the previous registered manager was in the process of de-registering.

Accommodation in the Ryde House unit, in the main house, was arranged over two floors which could be accessed by a staircase. There was a large lounge and a dining room, with smaller quieter rooms available for people and a large garden. The other four units were purpose built and each had a lounge, dining room and quiet areas. Most bedrooms in the purpose-built units had en-suite facilities. Each unit had its own garden and people across all five units had access to large communal grounds which included a private beach.

Staff knew how to identify, prevent and report abuse. Safeguarding investigations were completed and actions were taken in a timely way when safeguarding concerns were raised with the service.

There were sufficient staff employed to meet people's needs, keep them safe and provide them with person centred support. Recruitment procedures were robust and ensured that suitable staff were employed.

Individual and environmental risks to people were managed effectively. Risk assessments were reviewed as and when needed. Individual risk assessments identified risks to people, providing clear guidance to staff on how risks should be managed and mitigated.

Medicines were managed safely in all five units. People received their medicines as prescribed and there was a consistent system in place, with all the units using the same pharmacy.

Three of the units were clean and staff followed best practice guidance to control the risk and spread of infection. Two units had areas that were not clean. However, these were immediately addressed when brought to the attention of the senior managers.

Staff knew people well and had developed positive relationships with them. People were treated with dignity and respect and staff protected people's privacy.

People were supported to participate in activities of daily living within the home. Independence was promoted, with people being supported to maintain and learn new skills that would enable them to make choices about their own lives.

People received effective care from staff who were competent, suitably trained and supported in their roles. Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

Care plans contained detailed information to enable staff to provide care and support in a personalised way. People were empowered to make choices about all aspects of their lives. They had access to a range of activities suited to their individual interests.

Staff understood people's health needs and people had access to health professionals and other specialists when required. Procedures were in place to help ensure that people received consistent support when they moved between services.

The management team and staff worked collaboratively with other health and social care professionals to help ensure people received additional support when needed and there was a co-ordinated approach to their care and support.

There were robust auditing and quality assurance processes in place to review systems and allow ongoing learning and development.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff recruitment processes were robust to help ensure suitable staff were employed. Sufficient staff were employed to meet people's current needs.

Risks to people were robustly explored and recorded. The management team and staff had assessed individual risks to people and acted to minimise the likelihood of harm.

Staff understood their safeguarding responsibilities and knew how to identify, prevent and report abuse.

Medicines were managed safely and people received their medicines as prescribed.

Procedures were in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care from staff who were competent, suitably trained and supported in their roles.

Staff understood and followed the principles of the Mental Capacity Act 2005 (MCA). People's consent was sought prior to care being given.

Staff completed a thorough induction and training programme. Training for staff was updated regularly and specialist training was provided to meet people's specific needs.

People were supported to have enough to eat and drink and had access to health professionals and specialists when needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

Staff developed caring relationships with people and treated them with dignity and respect.

People's choices and wishes were respected.

People's cultural and diversity needs were explored.

Is the service responsive?

Good

The service was responsive.

People received care and treatment that was personalised and met their needs.

People's care plans were person centred and staff had the information they needed to support them as individuals.

Staff recognised when people's needs or behaviours had changed and responded appropriately and promptly.

People and their families were supported to complain and information was accessible to people. Complaints had been responded to and addressed.

Is the service well-led?

Good

The service was well-led.

There was a clear management structure in place and staff felt well supported and valued by the management team.

The management team promoted a positive culture that was person-centred, open, and empowering, which achieved good outcomes for people.

The management team and staff worked collaboratively with other health and social care professionals to help ensure there was a co-ordinated approach to the delivery of effective care and support.

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

The provider had suitable arrangements in place to support the registered manager and senior managers. There were robust

auditing and quality assurance processes to place to allow ongoing learning and development.

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.

The inspection was unannounced and was carried out on 10,11 and 13 September 2018. There were two inspectors and two experts by experience on the first day, two inspectors on the second day and two inspectors on the third day. 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 registered manager 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 any improvements they plan to make. We reviewed the PIR and other information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are information about specific important events the service is legally required to tell us about. We used the information to help focus the inspection.

During the inspection we spoke with four people who used the service and observed 16 other people who were unable to verbally communicate with us. We spoke to two of their family members during the inspection, and a further three family members following the inspection. We spoke with the registered manager of the service, the two senior managers, each unit manager and 18 care staff. We looked at care records for 10 people. We also reviewed records about how the service was managed, including safeguarding records and staff training and recruitment records.

Following the inspection, we received feedback from one social care professional and two healthcare professionals.

We last inspected the service in May 2017 when we did not identify any breaches of regulation, but rated the service as 'Requires improvement'.

Good

Is the service safe?

Our findings

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore House, Beech House and Silver Birch.

The service was safe. People and their family members told us that the service provided safe care. One person replied, "Yes," and smiled when we asked if they felt safe. One family member told us, "[Person's name] is happy, safe and well looked after at Beech House", while another relative told us, "I think it's a good place here. [My relative] is definitely safe here, [staff] are very kind; there's no nastiness or abuse." A third relative said, "[My relative] is definitely safe here."

We observed another person who had behaviours that could put themselves and others at risk. They were being supported by staff as they became distressed and agitated. Staff showed a high level of skill and followed guidance and risk assessments that were in the person's care plan. This meant that the person was supported safely and that others did not come to harm.

The health and social care professionals we spoke with told us they thought people were safe. One said, "They have good risk assessments and behaviour support plans that work for the individual people", while another said, "Staff listen to and follow advice."

People were protected from abuse and there were appropriate policies in place. Staff had received effective training in safeguarding adults and children, and were able to tell us what actions they would take if they suspected or observed abuse. One staff member told us, "If we saw something like malpractice we would report it." Another said, "I would go to the senior on shift and if there was nothing written up beforehand I would speak to management". They added, "I would go CQC or safeguarding if I needed to." Staff had contact numbers for the senior managers and unit managers, who could be consulted out of hours if a staff member had concerns. In addition, they had contact numbers for the local authority safeguarding team and Care Quality Commission. The registered manager, senior managers and unit managers were all aware of the action they should take if they had any concerns or a safeguarding issue was raised. There was a robust procedure for investigating any safeguarding concerns and records confirmed that the senior managers had investigated all concerns raised; had reported incidents appropriately and had promptly taken effective action where required.

Three of the five units were clean, however we found areas in two of the units that could pose an infection control risk to people. On the first day of the inspection we saw an area in the main house that was not clean and in Sycamore House one of the bathrooms required some maintenance to ensure that cleaning tasks could be completed effectively. We raised this with the senior managers who immediately acted to ensure cleaning tasks were completed thoroughly and the maintenance was completed in the bathroom identified. Some cleaning tasks were completed by staff employed for that specific role. However, other cleaning tasks were completed by the support staff on shift alongside the people living at the service who were encouraged to participate in some cleaning duties. There were processes in place to manage the risk of infection and personal protective equipment (PPE) such as disposable gloves and aprons, were available for staff to use.

Staff wore these when appropriate. Records showed that infection control audits had been completed and action taken where required. All staff had received infection control training and this was annually updated.

The laundry rooms in each unit were clean and organised and measures had been taken to ensure the risk of infection was minimised. Staff described how they processed soiled linen, using special bags that could be put straight into the washing machine to avoid the risk of cross contamination. A clear system was in place in the laundry rooms which had separate areas for clean and dirty linen to help prevent cross contamination.

People had individual risk assessments that were detailed and robust. Staff recognised risks that could impact on people and understood people's individual needs. This meant they could support people's independence whilst safely managing any risks. Where required, positive risk management plans were in place. These helped to ensure that if people made a choice to do something that involved an element of risk, effective and appropriate support was provided to keep them safe, while supporting them to continue to live full and active lives. For example, one person required a high level of support to be able to access the community safely. Their risk management plan was detailed and described to staff what the risks were and what action was needed to keep the person safe. This demonstrated that the service was proactive towards positive risk taking and supporting people to have opportunities and to access the community. Risk assessments and guidelines had been reviewed and updated regularly. Risk assessments for other people included; guidelines around managing behaviour that may challenge, eating and drinking, accessing the community and travelling in a vehicle, risks of choking and risks in relation to using the kitchen. Staff demonstrated good knowledge about different risks for each person and how to mitigate them.

Where an incident or accident had occurred, the provider had robust procedures in place to investigate the cause, learn lessons and take remedial action to prevent a recurrence. Staff had received specific training on managing risks such as those caused by behaviours and when we spoke to staff they were able to tell us which people were assessed as being at risk. The provider's human resources (HR) manager also carried out analysis on this information and provided a report to the provider, senior managers and the unit manager where the incident had occurred, enabling learning and risk identification across all the provider's services.

Safety checks had been carried out at regular intervals on all equipment and installations. Equipment, such as bath hoists were serviced and checked regularly. The temperature of hot water was monitored regularly by staff. This helped protect people from the risk of scalding. Gas and electrical safety certificates were up to date and the service took appropriate action to reduce potential risks relating to Legionella disease.

Fire safety systems were in place and each person had a personal emergency evacuation plan (PEEP) to ensure staff and others knew how to evacuate them safely and quickly in the event of a fire. Each unit carried out regular testing of fire equipment. The service is registered with the local fire brigade as 'urgent response' and therefore if they have to call the fire brigade they are a priority location, as the fire service understand that there are vulnerable people living in the units. Fire risk assessments were reviewed and updated yearly, with individual changes made as and when needed, such as if a new person should move in or someone's mobility changed. The provider ensured the premises and equipment were maintained. Health and safety records we looked at, confirmed regular environmental checks were undertaken and any issues were addressed quickly.

There were sufficient staff to meet people's needs and keep them safe. Staffing levels were based on the needs of the people living at the home. Some people living at the service received additional direct support from staff throughout the week to keep them safe and support them to participate in activities. The staffing levels in all the units provided an opportunity for staff to interact with people and support them in a relaxed

and unhurried manner. One staff member said, "People have staff to support them, there is enough of us." There was a duty roster system in place which detailed the planned cover for each unit. The duty roster showed that where people required direct additional support, this was provided. Short term staff absences were managed through the use of overtime and cover could also be provided where needed by staff from the other units that were part of the group.

Recruitment procedures were robust to help ensure only suitable staff were employed. Staff files included full employment histories and records of interviews held with applicants, together with confirmation that pre-employment checks had been completed before the staff member started working at the service. These included Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions. DBS checks were renewed every three years to help ensure that staff continued to be suitable for employment. References had also been sought from relevant people to check applicants were of good character.

People received their medicines safely and the staff carried out a daily audit to ensure all medicines had been administered correctly. There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. The senior management team had recently reviewed the medicine systems in each unit and had made changes, so that there was consistency across all five units. Medicines administration records (MAR) provide a record of which medicines are prescribed to a person and when they were given and these were completed correctly.

Guidance was in place to help staff know when to administer 'as required' (PRN) medicines, such as medicine to be given to support epileptic seizures and pain relief. Each person who needed PRN medicines had clear information in place to support staff to understand when these should be given, the expected outcome and any action needed if that outcome was not achieved. People had medicines care plans that detailed how they needed support to take their medicines and included a photograph of the person, their GP details and when they had to take their prescribed their medicines. For example, one person's medicines care plan said '[Person's name] will take his medicines with any drink, but prefers squash or tea,' and another person said, '[Person's name] prefers his medication to be placed into his hands.'

The provider had a policy for when staff were required to administer medicines covertly. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. We saw that when people required covert medicines, there was clear guidance for staff, risk assessments were in place and authorisation from relevant medical professionals was recorded. Staff regularly had their competency checked for administering medicine. This meant that any issues could be addressed promptly and additional support or training provided if required.

Good

Is the service effective?

Our findings

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore House, Beech House and Silver Birch.

Staff received effective and detailed training that enabled them to carry out their role. People's families and health and social care professionals described staff as being well trained to carry out their role. One healthcare professional said, "Staff are proactive, on the ball and will pick up on issues or concerns about people's health quickly", while another said, "Staff and managers here are good at assessing people's needs and meeting them."

Staff received training in different formats to meet their individual learning styles and subject matter. These included practical face to face workshops and individualised e-learning. There was an electronic system to record the training that staff had completed and to identify when training needed to be repeated. One staff member told us, "I have thorough training, the autism training is amazing." Another said, "The training here is fantastic. I have more qualifications now than I ever had at school." A third said, "The training is really good, we get lots of training." The training staff had completed included essential training, such as fire safety, medicines training, moving and handling and safeguarding adults. Staff were also provided with additional training which focused on the specific needs of people using the service, such as epilepsy, Makaton, a type of sign language used by people with learning disabilities, autism awareness, dementia awareness, Mental Capacity Act and PROACT SCIP training. PROACT SCIP training provides staff with a positive range of options for crisis intervention and prevention, when supporting people who occasionally had behaviour that could place themselves or others at risk.

People were supported by staff who had received an induction into the role prior to starting work. New staff were provided with a workbook and a detailed induction checklist, which supported them to learn their new role so that they could meet the needs of people effectively. In addition, staff completed the provider's mandatory training and worked alongside more experienced staff until they felt confident and were competent to work directly with people. One staff member told us, "When people go into crisis there's always someone there to help you, you're never on your own, the senior staff are supportive". Staff that were new to working in care were also required to complete the Care Certificate, which is a set of standards that identifies the knowledge and skills and behaviours of staff working in social care.

Staff received regular supervision which enabled the provider and senior managers to monitor and support staff in their role and to identify any training opportunities. Staff who had been employed at the service for more than a year received an annual appraisal. One staff member told us, "I get supervision every two months," and another said, "I get supervision about every three months, but I can talk anytime, the manager's door is always open." Staff told us they felt supported by the unit managers and senior management team and that they could go to them with any concerns. A third staff member said, "Supervisions are really good, they let you speak and we get a change to raise any questions or queries."

Staff protected people's rights by following 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 the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. During the care planning process, the unit managers and senior staff had assessed people's capacity to make specific decisions, such as for receiving medicines, managing finances and support with personal care. Where people had been assessed as lacking the capacity to make certain decisions, staff acted in people's best interests by making decisions on their behalf and providing appropriate care. These were recorded and showed that the unit managers and senior staff had consulted with others involved in the person's life when making these decisions. One relative told us, "[Person's name] is able to make their needs and wishes known and staff act in their best interests and care about them."

Staff were knowledgeable about how to protect people's human rights. Staff described how they sought verbal consent from people before providing care and support and we observed staff in each of the five units asking people for their consent when they were supporting them. For example, one staff said, "I'll ask [person's name] if you can look in her room first." We also observed one staff member say to a person, "Is it alright if you put your hat on, it's hot outside." Staff told us that they always offered people choice and involved them in everything that happened. One staff member said, "People have a lot to do and always get a choice", while another said, "Some people can easily choose themselves, but there's some who need just two choices so it's not overwhelming for them".

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager and senior managers had ensured that these authorisations had been applied for where necessary and these were reviewed when required. Some DoLS applications had been authorised and others were awaiting assessment by the local authority. Information about which people were subject to a DoLS authorisation was in their care records and when we spoke with staff, they could identify which people had a DoLS in place.

People were encouraged to maintain a healthy, balanced diet, based on their individual needs. People could access food and drink when they wanted to and were supported by staff who had received food and hygiene training. For example, in one unit we saw a person being supported by a staff member to make themselves some toast and a hot drink and in another unit a person was making themselves a drink independently. All five units used food menus that were presented in a pictorial way and were changed each week. However, staff told us that if people did not like what was on the menu, there was always something else they could have. One staff member told us, "Lunch is wherever and whenever people want it, they request when they want to eat, some like to sit together and some sit in their room. We use choice boards and a menu to help them decide." Staff knew what people liked and disliked and where people had specific dietary requirements, staff were knowledgeable and there were detailed risk assessments and guidance in people's care plans.

People received annual health checks and were supported to maintain good health, with access to appropriate healthcare services. The senior management team, unit managers and staff consulted effectively with external healthcare professionals in a timely way. Staff knew people's health needs and could describe them to us. Care plans contained details of specific health needs that people had, with guidance for staff to follow. Records showed that people had regular appointments with healthcare professionals, such as speech and language therapists, learning disability nurses, psychiatrists and doctors. For example, we saw a learning disability nurse visiting a person and spending time talking to the staff to

ensure they were all working together in the best interests of the person.

The service used a 'red bag' system to ensure that people received consistent care and support if they had to move between services. Each person had a red bag which contained all their essential information, including information about their general health, current concerns, social information, abilities and level of assistance required. This allowed person centred care to be provided consistently.

The environment in all five units was suitable for the people living in them. Four of the five units had been specifically built and designed to meet people's needs and had a range of communal rooms and outside spaces that people could use. There was assistive technology such as sensors to turn on taps and to flush the toilets to assist people to be independent. The main house was an older building that was subject to planning restrictions. However, this had recently undergone some decoration and redesign and work was on-going to ensure it was a suitable environment for the people living there.

Good

Is the service caring?

Our findings

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore House, Beech House and Silver Birch.

People and their families told us the staff were caring. Families could visit their relatives whenever they wanted, but staff sought permission from people to ensure they were happy to receive a visit. A relative told us, "Anytime we want, we visit, they're [staff], happy to talk to us. I always feel welcome, oh crumbs I never feel in the way." A person who lived at the service told us, "Staff listen to me. I can see a change now, it's a happy place to live." Another person said, "I like it here, I do, I play bingo and I go to discos, I do colouring and jigsaws, I'm happy here, I've got a nice big room."

People were spoken to by staff with kindness and respect. We observed positive interactions between people and staff in all five units and people seemed happy and relaxed. Where people had different communication needs, staff communicated in ways that enabled people to understand and make choices. For example, some people were unable to communicate verbally and staff used pictures, symbols and objects to assist people to understand what they were staying. In addition, staff used Makaton, which is a type of sign language used by people with a learning disability. For example, we saw one staff member kneeling in front of a person who was in a wheelchair and who had no verbal communication. Staff made sure the person could see them and spoke in a gentle and reassuring way, explaining what they were asking at a speed that the person could understand. The person smiled and nodded their head to show they understood at the end of the conversation. Another staff member was observed supporting a person to complete a task that they were finding challenging. The staff member said to the person, "Good man, you're doing great, well done." The person smiled which was reciprocated by the staff.

One family member said, "I am very impressed with the quality of care Beech House staff give to my [relative] and us as a family, the manager and staff have been incredibly supportive, kind and compassionate, helping the whole family through a tough stage. Another told us, "My relative seems very happy and content, the staff are very friendly and supportive", while a third said, "Staff are very competent and there is a real family atmosphere and I'm always made to feel welcome."

The healthcare professionals we spoke with told us that staff were caring, compassionate and made sure they understood people's needs well. One healthcare professional told us, "The staff have demonstrated a motivated, positive and caring approach to supporting [person's name]." In addition, they said, "We were impressed by staff engagement and enthusiasm during a recent workshop around one person's support needs."

We observed a friendly and relaxed atmosphere in all five units. For example, in one unit we saw a person come in from being out in the community. They saw a member of staff and rushed to greet them with a big smile on their face. The staff member smiled back and the person put their arms around the staff member in greeting. In another unit music was playing, people were smiling and laughing and singing along. One person got up to dance and a staff member joined in. The atmosphere was jovial, relaxed and calm.

Although the service employed a high number of staff across the five units, each unit had its own staff team that knew people well. Staff told us they enjoyed working at the service. One staff member said, "I love everything about my job. To go home and to know you've helped, to see them smile, it means everything", while another said, "I've been here for nine years; nearly a decade. I wouldn't have been here this long if I didn't love my job, you build bonds." People had keyworkers who were key members of staff that were allocated to provide additional support to one person. Their role included supporting the person to maintain contact with family members and friends and to access activities that that's the individual person may enjoy. Keyworkers also ensured that people had the opportunity to purchase essential personal care items and other shopping items of their choosing.

People's independence was valued and promoted by staff. Staff took the time to work with people individually so that they could maintain independence and develop new skills. For example, we observed staff supporting people to make drinks and participate in activities that they chose. Although staff did the majority of cleaning and domestic tasks, people were supported to be involved and where possible do things for themselves.

Staff respected people's privacy and dignity. We observed staff knocking on doors before entering rooms and ensuring doors were closed when supporting people with personal care. Care records for people were kept securely in the offices of each unit and were only accessible to staff. The senior managers told us that people's cultural and diversity needs were explored during pre-admission assessments and included people's specific needs in their care plans. This included people's cultural and faith needs and whether they preferred male or female staff to support them with personal care. Further information was included in an 'All about me' care document and contained clear information about people's backgrounds, wishes and life goals. Records for each person gave staff an insight into the person's interests, background and relationships that were important to them. Staff had a good understanding of people's histories and gave examples of how they used the information to support people.

Staff demonstrated a person-centred approach and understood people's needs well, including their likes and dislikes and family histories. For example, we saw that one person's room had been decorated with items relating to a singer that the person liked. Staff told us that the person really enjoyed spending time listening to the music of this singer and looking at the posters. Another person was very sensitive to the noises and behaviours of others in their home. Staff were aware of their specific needs in order to prevent them becoming distressed. During the inspection we observed the person starting to become distressed. Staff were very quickly able to use their knowledge of the person to support them to relax and avoid an escalation into crisis.

The registered manager and senior management team were aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the person they are supporting to help make decisions that they believe the person would want. We were told that advocates had previously been used to support people and the management team knew where and when to contact them and had done so to support people to make important decisions.

Good

Is the service responsive?

Our findings

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore House, Beech House and Silver Birch.

People and their families told us that they received personalised care and support that met their needs. One family member said, "[Person's name] has been out consistently and is having a much better quality of life, they go out several times a week." Another family member told us, "My [relative] had gone into crisis and the risks were serious. Beech House staff were absolutely wonderful in the way they supported [my relative] and us as a family." In addition, one person told us," I like it here, they're nice to me. I've got everything I need in my room."

People had individual care plans that contained information including their personal history, their health needs, their likes and dislikes and behaviours. Care plan records were person centred and captured the individual information about each person. For example, care plans detailed when people liked to get up and how they liked to be supported. One person's care plan said, 'One staff member is to assist me with washing when in the bath and another staff member is to pour water on my hands as I enjoy this.' People's care plans contained details which enabled staff to recognise when they were feeling anxious or upset, to prevent behaviours that may cause themselves or others risks. One person's care plan had a 'feelings chart', which described for staff how the person may be feeling. Their care plan stated, 'How you will know I'm happy - I will smile, laugh, clap my hands and rock while humming.' This demonstrated that the management team and staff knew people well and had developed care plans that captured essential information about each person to ensure their needs were met.

Some people living at Ryde House had complex needs and behaviours and required detailed risk assessments and behaviour management plans. The management team and staff had a detailed understanding of individual people's needs and staff responded appropriately and in a timely way. Records showed that when people had episodes of behaviour that placed themselves and others at risk, these were analysed and care plans and risk assessments were reviewed and updated. For example, we saw one person's behaviours had recently changed and was placing themselves and others at risk. The unit manager and staff had liaised with external health professionals to identify potential causes. As a consequence, medical intervention had been provided and the person's care plan and behaviour management plan were updated, resulting in a reduction in behaviours that caused risks.

When possible, people were involved in creating their care plans and in reviews to update them. Monthly reviews of care plans were completed by key workers and people were encouraged to participate. Care plans were also available using pictures and symbols to assist people to understand them. Daily records of the care people received were detailed, up to date and showed that care was being provided in accordance with people's needs. For example, where people had been assessed as requiring direct support from a staff member, records showed that this was being provided.

Families were kept informed of changes and were involved in the developing and reviewing of people's care

plans, where permission was given or where people had been assessed as lacking capacity to make certain decisions. One family member told us, "They'd contact us if anything happened. We call every single day and they're so nice about it." Another said, "We were concerned about the way [my relative] was behaving, we mentioned it and straightaway they [staff] asked for a meeting with us. They said, 'We want to make sure you're happy with what we're doing.' If I have any worries I feel very confident to say." A third family member told us that their relative had physically and emotionally improved since living at the service. They said, "Things have turned around, my [relative] is eating better and is much happier."

People were actively involved in accessing their community and participating in activities they chose. Some people attended day services within the community and others went to 'Willow Village' (a day service in the grounds of the Ryde House Group complex). People were also supported to attend a local disco which was run by the Ryde House Group corporation held in the community. There were regular opportunities for people to go out with staff. Activities included going out, shopping, for coffee, for meals out and to participate in leisure activities, such as bowling or swimming. One person had shown an interest in playing darts. The staff had found a local darts team and supported the person to attend, so they could play darts as part of a team each week. Other people who lived at the service took part in voluntary work by delivering a local newsletter to houses in the community which staff supported. A staff member told us, "People all go out every day. They went to the 'One Life' festival, it's especially for people with learning disabilities and autism, it was great. They do group activities if they want to but some people prefer being on their own. They go to the cinema and to bowling." In addition, some people attended a local education facility and were supported to travel there and back with staff.

People were supported to be involved in the activities of daily living including cooking, doing their laundry and keeping their bedrooms clean. One staff member told us, 'It's a lovely team here, we support each other. We encourage people to be involved and helped them to do as much as they can."

All staff were expected to complete training in equality and diversity to ensure that there is a culture of inclusion and empowerment for people to be themselves. The provider had policies that considered people's human rights including sexuality, cultural and religious needs. Staff supported people to follow their specific life choices where required. There had been a recent 'Isle of Wight PRIDE' event which people and staff attended together. Staff told us that this was a positive experience where people could feel part of their community and celebrate differences. One staff member told us, "Seeing them [people] happy, makes me happy. It's giving them independent living and taking them out into the community, I just love it."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. The service was compliant with the AIS, which meant that information was provided in an accessible format to aid understanding for the people living at Ryde House. For example, all menus, the activity options, minutes of meetings and notices displayed were available in both picture and written format.

The provider had a complaints policy and procedure in place. As with all other documentation we looked at, the complaints procedure was also displayed in an easy read and picture format. Records showed that when complaints were received these were investigated robustly and people and their families where appropriate, received feedback. The senior management team recognised that some complaints could only be made through the use body language and behaviour, for example from people who had no verbal communication.

Technology was utilised to assist people to live more independent lives. For example, the units had motion

sensors for turning on and off taps, showers, and for flushing toilets. People also had use of sensor mats to monitor epilepsy and sound monitors were used for people with identified risks, to enable them to have time alone in their rooms, but for staff to be alerted when needed. Wireless internet was available for people in all units and many people used handheld computers to assist communication and for leisure.

At the time of the inspection, no one using the service were receiving end of life care, however in one unit they had recently supported someone who chose to remain at the home at the end of their life. The unit manager described how they had worked closely with the local hospice, healthcare professionals and family members to help ensure the person's needs could be met and that they received appropriate support at the end of their life. Staff had received end of life training and the management team were currently in the process of creating an advance care planning tool to help ensure that people's end of life wishes were respected.

Good

Is the service well-led?

Our findings

We received positive feedback about the management for Ryde House. Comments included, "The managers are good at communicating and are proactive" and "The manager [unit manager], and new deputy manager are really good to work with, they are positive, hands-on and person centred. They are good at communicating and responding to concerns."

Ryde House was split into five units; the main building Ryde House and four separate purpose built buildings. Maple Tree, Sycamore House, Beech House and Silver Birch. At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Since the last inspection the provider had reviewed their management structure and had appointed two senior managers. They told us that the two senior managers had commenced the registration process with the Care Quality Commission (CQC) to become joint registered managers of the service. The current registered manager was also the nominated individual for the provider. We were told that they would continue as the nominated individual, but would de-register as manager once the new senior managers were registered.

At the last inspection, in June 2017, we found that the service required improvement. At this inspection we saw that improvements had been made where needed. The directors of the provider's company had considered the management structure and the previous lack of consistency across the five units. This had been addressed with improved management oversight.

Prior to this inspection the two senior managers had taken over the overall running of the service, with support from the current registered manager and directors of the provider's company. Unit managers and the unit deputies told us that they felt supported by the senior management team and could seek advice and guidance. One told us, "I'm really happy here, all the units communicate well with each other. They [senior managers] are all trying to bring us all in line with each other. Once every two months we have a focus review meeting. Our next one is about medicines." Another unit manager told us that they felt the company was very supportive and they received good quality training to do their role.

The provider had robust quality assurance procedures, which included; daily recording audits, medicine audits, care records audits and analysing complaints, accidents and incidents. Furthermore, safeguarding concerns were reviewed for trends, to ensure that there were not repeated failings within the care and support being delivered. Six monthly peer audits were completed for each area of the service, which involved unit managers auditing another each other's units and providing feedback for on-going learning and development. In addition, the chief executive officer (CEO) carried out three audits per year of the service, produced feedback of their findings and developed an action plan which they monitored for development.

The provider carried out unannounced internal audits of each unit every year and health and safety audits every two months. Areas looked at included, health and safety, infection control, safeguarding, the environment and emergency evacuation plans. This demonstrated a robust system and we saw records that showed when issues were identified, action plans were made with timescales for work to be completed. In addition, unit managers completed audits of each other's homes to ensure consistency within the service. They told us that these were done at any time of day or night and included observations of interactions between staff and people and considered dignity, privacy, respect, communication, care plans, moving and positioning, choice, independence and person-centred support. Unit managers then received feedback with an action plan for any work that had been identified as requiring improvement, which was shared with the whole management team. Furthermore, unit managers reviewed people's daily records and used staff meetings and handovers between shifts, to consider people's views of the service.

Staff told us that they felt very supported and that managers were approachable. One said, "The company are nothing but supportive, the managers and deputy managers are so nice they were so welcoming to me." Another said, "I think the company is good, they supported me a lot. I have had a tough time personally and they had been absolutely brilliant." A third said, "My unit manager is amazing, they encourage us to learn and develop and are always there to give advice, if they are not here we can call them any time."

The service had an 'employee of the month' scheme in place, which demonstrated that staff were valued. Each month staff could vote for a colleague due to something positive they had done to support a person or other staff member, and the winner received a gift voucher. Staff also had access to a company counsellor and were supported to access this if required. A dedicated employee intranet website was available to staff to provide them with important information about changes to the organisation and advice around where to get particular personal support. This also provided staff with useful information and guidance to promote staff wellbeing and safety.

Feedback was sought from families, professionals and staff in the running of the service and was received through informal chats, regular meetings and specific focus groups. Staff were also encouraged to regularly feedback via a staff online portal about the service delivery, and share ideas and suggestions on how the service could be improved. Quality assurance questionnaires were sent to people, their families, staff and professionals annually. Feedback gathered was analysed by a computer based system, which created an anonymous report that was shared with the CEO and management team. The feedback also generated qualitative and quantitative data to support the management and staff to ensure improvements could be made. In addition, the provider told us that they were trying to start a resident's 'family voice' group, which would be a positive way to find out family members views or concerns on the service and for the provider to give feedback, information about future plans or events and to offer free training for them.

Ryde House had extensive policies and procedures in place to aid the smooth running of the service. For example, there were policies on safeguarding, human rights, equality and diversity, complaints and whistleblowing. Staff knew how to contact external agencies if they felt they were unable to raise concerns internally. The provider had a duty of candour or policy that required staff to act in an open and transparent way when accidents occurred. Although the two senior managers had not yet been registered with the Care Quality Commission (CQC), they understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and events that were required. Business continuity plans were in place to ensure that individuals were prioritised in terms of risk during crisis situations.

The management team kept up to date with the latest guidance and best practice by monitoring updates from organisations such as the National Institute of Care Excellence (NICE), the Health and Safety Executive (HSE), Diabetes UK, Dignity in Care, Alzheimer's Society, NHS Choices, and, Public Health England. In

addition, a representative of the management team attended a local care home forum and worked with a local authority commissioning team and NHS medicines team to consider best practice. This information, along with good practice identified in individual units, is shared with the rest of the management team at their regular meetings.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in June 2017, was displayed in the units and there was a link to the CQC's rating on the provider's website.