Isle of Wight Council

Plean Dene

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

This inspection took place on 1 and 4 May 2018 and was unannounced. One inspector carried out the inspection on the first day and two inspectors on the second day.

Plean Dene is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Plean Dene is a local authority residential care home which provides accommodation for up to thirteen people with learning disabilities including Autism who need support with their personal care. At the time of our inspection there were nine people living in the home.

The home was arranged over two floors with most of the bedroom accommodation on the first floor. There were bathrooms available to people on each floor. There were three communal areas in the home, which were a dining room, a quiet sitting area and a lounge. There was a large garden that people could easily access. People could use the kitchen with staff members supporting them.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The last comprehensive inspection of this service was in February 2016 when the service was rated Good. At this comprehensive inspection we found the service remained good.

Quality assurance systems had not highlighted some shortfalls in the provision of mandatory training. We have made a recommendation about this.

The principles of the Mental Capacity Act 2005 were not being followed as required; best interest decisions were not in place for all people that required them. Consent was not being sought in line with legislation.

There were not effective systems in place to ensure that staff received training necessary to their roles. We have made a recommendation regarding this.

The risks relating to people's health and welfare had been assessed. However, they were not consistently recorded and therefore the information was not always clear.

The environment was clean and well maintained. Environmental risks were assessed robustly and processes were in place to audit and maintain the safety of people in the home.

Where accidents, incidents, and near misses had occurred there was an effective system in place to ensure that appropriate action was taken to mitigate any risks or prevent reoccurrence.

There were robust arrangements in place for the safe recording, storage and administration of medications.

People's families told us they thought the home was safe. The provider had appropriate policies in place to protect people from abuse and had robust recruitment procedures. Staff had received safeguarding training and demonstrated an understanding of the action they would take if they identified any concerns.

People were supported to have enough to eat and drink and were encouraged to make choices. Staff supported people to eat and drink, when necessary and encouraged people to be as independent as possible.

There was enough staff to meet people's needs and to enable them to support people to engage in activities and access the community. Staff provided person centred care and knew people's needs well. They spoke to people with kindness using good communication methods and showing dignity and respect.

The registered manager understood their responsibilities for end of life care and knew how to access relevant support if needed.

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 remains Good

Risks to people had been assessed although these were not consistently recorded.

Staff demonstrated a good knowledge of how to protect people from abuse and avoidable harm.

Safe recruitment practices were followed to ensure employees were suitable to work in a care setting.

Medicines were recorded, stored and administered safely.

There were enough staff to meet people's needs.

Is the service effective?

Good

The service remains Good.

Staff were not always provided with mandatory training.

Staff received regular supervision and appraisals.

People had enough to eat and drink and were involved in making informed choices.

People were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service remains Good

Staff were relaxed and friendly and appeared to know people well.

Positive communication methods were used to enable the people to understand and be involved in their lives.

Staff spent time supporting people with activities and engaged them in everything that was happening in the home.

Care plans and confidential documents were securely stored.

Is the service responsive?

Good

The service remains Good

People received personalised care and support that met their individual needs.

Care plans were detailed and explained exactly how each person liked to be supported. Photographic care plans were being developed for all people and positive communication methods were used including objects and pictures to aid understanding.

People were actively supported to be involved in making choices about what they wanted to do.

People had access to a range of meaningful activities in the community suited to their individual interests and needs.

Is the service well-led?

Good

The service remains Good.

The provider's quality assurance systems had not always ensured that staff had been provided with mandatory training. We have made a recommendation about this

There was a clear management structure in place. Staff were organised and communicated effectively as a team

Environmental risks were monitored effectively.

The registered manager and staff had developed a positive culture where people were involved in decisions and supported to do as much for themselves as possible.

Community links had been developed and new opportunities were actively sought.

The manager had positive links with other homes and had actively worked to make improvements to the service.

There was a contingency plan to deal with foreseeable emergencies.

Plean Dene

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 was a comprehensive inspection. The inspection took place on 1 and 4 May 2018 and was unannounced. One inspector undertook the inspection.

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 improvements they plan to make. We reviewed the PIR, previous inspection reports and notifications the provider had sent us. A notification is information about important events, which the service is required to send us by law.

We engaged with two people, who communicated with us verbally in a limited way and observed another five people. We were unable to have coherent conversations with all people living at the home due to their learning disabilities. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five staff and the registered manager. We spoke with two family members and two external healthcare professionals. We looked at care plans and associated records for four people, staff duty records, staffing records of three staff, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in February 2016 when it was rated as Good.

Good

Is the service safe?

Our findings

People were safe however; they were unable to tell us if they felt safe or have coherent conversations with us because of their learning difficulties. Families told us they felt that their relatives were safe. One said, "I'm sure they are safe." While another said, "I have absolutely no concerns about [person's name] safety at all." We saw staff helped people when required and used mobility aids and equipment when needed.

Risks to people had assessed. We looked at four care files and although people's individual risks had been assessed, these were not consistently recorded, with different types of recording methods being used for different people. Some risks were recorded on a risk balance sheet while others were identified in guidelines about how to support a person. Although risks were identified, the information was not always clear. We discussed this with the registered manager who told us that they had recognised that risks were not recorded using the same method and assured us that they were in the process of addressing this so that there was consistency and clear information for staff. Risk assessments and guidelines had been reviewed regularly and kept up to date and included guidelines around managing behaviour that may challenge, the use of safety equipment to help people to move, risks around eating and drinking and risks about accessing the community. Staff confirmed they understood the risks for each person and we observed staff following guidance around safely moving people throughout the inspection. This meant that staff were able to use information in people's care plans to support people safely.

Environmental risks had been assessed and were monitored appropriately to ensure that people living at the home were protected from avoidable harm. We looked at records which showed that essential checks had been completed on the building and equipment around the home which was in use, such as a bath hoist and sensor mats. This meant that people could be assured the equipment in use was safe and that sensor mats would alert staff when needed. The provider has a duty to maintain the health and safety of the building and we saw records that showed that gas and electrical appliances were serviced routinely. Temperature checks of all hot water outlets were also completed weekly and an external organisation carried out necessary checks each month, to prevent the outbreak of legionella.

There were policies and procedures for staff to follow in the event of an emergency and each person had a personal emergency evacuation plan (PEEP). These were detailed and considered the person throughout the evacuation procedure. For example, they contained details about each person's needs, any support they may need to walk and how many staff would need to support them to evacuate. The home had recently had a thorough fire risk assessment which looked at the building, the staffing levels and evacuation processes. This was carried out by the fire service and no risks were identified. Some minor recommendations were made and these were actioned immediately by the provider. Fire drills had taken place, which enabled staff to be clear about what to do in the event of a fire. Arrangements were in place to accommodate people at another home owned by the provider, should this be required in the event of an emergency evacuation. The provider's policy was that fire detection and management equipment would be tested weekly, and this was being done.

The provider had appropriate policies in place to protect people from abuse. Staff had received training in

safeguarding adults and they were able to describe the actions they would take if they suspected or observed abuse. There was a multi-agency safeguarding policy in place for the home, which was accessible to all staff. Contact numbers for the registered manager, the home's senior staff, the local authority safeguarding team and Care Quality Commission were also readily available to staff. The registered manager told us that in addition, the provider ensures that there is always a manager on call outside of the core hours of work, in case of emergencies. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. Records confirmed that the registered manager had reported incidents appropriately and promptly to the local safeguarding authority.

The provider had robust recruitment procedures in place, which included seeking previous employment references, obtaining appropriate identification and completing checks through the Disclosure and Barring Service (DBS) before staff commenced their employment. We looked at three staff recruitment files, which all contained the relevant documentation. This meant that the provider could be assured that the people they employed were suitable to work with people who use care and support services. The recruitment process was managed by the provider's business support team in conjunction with the registered manager.

The registered manager used a duty roster system, which detailed which staff were working and ensured that there were sufficient staffing levels to meet the needs of the people. The duty roster showed that there was a senior staff member on each shift, who had responsibility for ensuring people's needs were met and for administering medicines. The registered manager told us that short-term staff absences were usually covered by the existing staff team or by the provider's internal ad-hoc staff. The registered manager told us that they had not had to use staff from an external provider for many months and therefore people were supported by staff that were familiar to them. Some people required the direct support of a staff member at times. This had been assessed and we saw from records and our observations that this was being provided. This ensured that people had their assessed needs met.

The provider had a policy in place to prevent and control the spread of infection which included the reporting of infectious diseases. Staff used personal protective equipment (PPE), such as gloves and aprons when supporting people with personal care and we saw PPE was available throughout the home for staff to use. Staff were encouraged to receive an annual flu vaccination offered by the provider. The registered manager told us that infection prevention and control was discussed with new staff members during their induction period and there were plans for further infection and control training to be delivered for all staff. Cleanliness was maintained throughout the home.

People's medicines were recorded, stored and administered safely. Staff had received appropriate training and medicines administration records (MAR) were completed accurately. There were audit processes in place to ensure medicines were correctly received into the home and administered to people. There were secure systems in place for staff to transport, administer and return people's medicines if they went out for the day. When people required 'as and when' (PRN) medicines such as for pain relief, staff had clear guidance to follow. The guidance detailed how staff would asses someone who could not verbally communicate, to identify if they were in pain. This meant that staff would only administer medicine when they had assessed that it was needed.

The provider had an accident and incident reporting system. We reviewed incident and accident records for three people. The records showed that staff reported incidents and accidents promptly and took appropriate action to keep people safe. Themes and patterns were analysed by the registered manager and information about any incidents or accidents was shared at the handovers between staff from one shift to another.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 made on their behalf must be in their best interests and as least restrictive as possible. Some records did not show how best interest decisions had been made and who had been consulted, as required by the MCA Code of Practice. We looked at the care plans of four people that had been assessed to lack capacity for certain decisions. Best interest decisions had only been completed for one person. We discussed this with the registered manager who told us that the provider had given them new documentation for best interest decisions. These would be completed for all people, and would take family members and other relevant people's views into consideration. However, this meant that the provider had failed to ensure the legal requirements of the MCA had been met for people using the service.

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 had applied for authorisations under the safeguards for people where necessary and these were reviewed when required.

We saw records recorded by external health professionals that showed decisions for some restrictive practices had been agreed with them. We discussed the need to ensure that restrictive practices were being used in line with the MCA Code of Practice with the registered manager on the first day of the inspection. On the second day of our visit we saw that one person had a new best interest decision recorded in relation to the restrictive practice.

Healthcare professionals told us the staff were well trained to meet people's needs. One healthcare professional said, "The staff have been amazing and worked really hard with one person to make sure they were involved every step of the way, this made a real difference to the outcome for that person." Families of people using the service told us they also felt the service was effective and one family member said, "Staff always give [person's name] respect and they support them to do the things they want, not want they [staff] think should happen."

Staff encouraged people to make their own decisions about everyday choices. For example, we saw staff supporting people to choose what they would like to eat or where they wanted to go out. One staff member said to a person they were supporting, "Where would you like to sit, would you prefer the lounge or the conservatory?" We observed staff communicating choices to people throughout our visit and this appeared to be a natural and automatic process. People who were not able to verbally indicate their choices were given visual options either by staff showing them objects, or by staff supporting people to show them their choice. For example, one staff member was asking if a person wanted a drink. They then said to the person, "Show me." The person then walked into the kitchen with the staff member to look at the options and chose what they wanted.

We looked at staff training records following the inspection, which showed that the provider had a mandatory training programme, which new staff had completed. This included safeguarding, fire safety, first aid, moving and handling training and infection control. Although staff said they had received training from the provider, we identified areas where improvements were required. For example, we saw that mandatory training updates had not been kept up to date for all staff. Out of 21 staff employed at the home at least 11 staff had not received health and safety training for over two years and another seven staff had not received infection control training for over three years. The provider had failed to ensure that staff had received training which was relevant to their role and required to keep people safe. We discussed this with the registered manager who told us that they had requested this mandatory training for staff but the provider had been sourcing an alternative training resource and this had caused delays in the mandatory training being provided. However, staff had recently received training in other areas such as person-centred care, mental capacity act awareness, safeguarding and fire safety.

We recommend that the provider ensures that all staff consistently receive training which has been identified as mandatory

Staff received an induction into their role and also worked alongside more experienced staff when they first started employment. We saw that they had relevant qualifications such as vocational qualifications in health and care or the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us that all new staff completed the provider's induction and if they had not already achieved it, would undertake the Care Certificate or equivalent qualifications. Potential new staff were shown around the home and introduced to some of the people using the service as part of the interview process. The registered manager told us that where possible, feedback was sought from people living at the home, to give their initial views of the potential new staff member. New staff employed to work at the home received a two week shadowing period and were supported to receive extra shadowing shifts if needed.

Staff were supported in their role through the use of regular supervisions. Supervisions and appraisals provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and consider learning opportunities to help them develop. Anyone who had been employed by the service for longer than one year also received an annual appraisal. We looked at staff supervision records for three people working at the home, which showed evidence of supervisions taking place regularly as planned and different aspects of their job role being discussed as a focus area. The registered manager told us that where staff had raised any issues around training needs or a progression opportunity, they were supported to achieve this where possible. For example, there had recently been an opportunity for a senior care post within the home, which was filled by a staff member who had been identified as wishing to progress within supervisions.

People's needs were met by the adaptation, design and decoration of premises. The home had wide corridors and large rooms and there was plenty of space for people to choose where they wanted to sit, such as quieter areas of the house. The registered manager told us that they had recently had new carpet throughout the home and had also had new furniture for the lounge. Each person's bedroom had been adapted to meet their needs and the home's bathrooms had hoists and specialist baths to meet the needs of the people living at the home.

People were provided with suitable and nutritious food and drink. We saw that there was a four weekly menu that staff told us had been designed in line with what food people liked and disliked. The menus were reviewed and changed with the seasons and we saw evidence of new menus that would have photographs of the meals next to the choice. We were told by the registered manager that staff were in the process of

photographing every meal, drink and food choice so that they had a catalogue of visual options that people could choose from more effectively.

People were supported to maintain good health and had access to appropriate healthcare services. Records showed they had regular appointments with health professionals, such as chiropodists, speech and language therapists, nurses and GPs. One person required regular visits from a healthcare professional and they told us that the staff and registered manager worked closely with them to follow any guidelines and to maintain the person's health and wellbeing. If people needed to go to hospital, the home used a system which ensured that relevant records such as information about their care needs, communication needs and details of any medicines they were prescribed, were transferred with them. This ensured a continuity of care and the registered manager told us that she would also liaise with the hospital and when possible send staff to support the person.

Staff were kept up to date about people's needs through handover meetings, which were held at the start of every shift. Information provided to staff included details about people's emotional and physical health needs and meant that staff worked together to ensure that people's on-going needs were met.

Technology was being used to alert staff to when people required assistance at night, such as door alarms and sensor mats. We were told by the registered manager that one staff member brought in their own personal electronic tablet to support people with communication tools and for other entertainment. This was being monitored by the registered manager and was only used in communal areas by the staff member who owned the tablet. However, the home did not provide access to technology such as computer tablets or sensory equipment.

Good

Is the service caring?

Our findings

The home environment was relaxed and friendly and staff appeared to know people well. We were unable have coherent conversations with people at Plean Dene because of their learning difficulties but observed people looking relaxed and content throughout the inspection. Family and friends were free to visit whenever they wanted to and they told us that they thought the staff were caring. One family member said, "The staff always take their time with [person's name] and they seem to care that they are doing the right thing for them." Staff members used people's names when they spoke to them and we saw them respecting people's dignity. For example, one person needed to go to the bathroom to change their clothing. A staff member discreetly spoke to the person away from other people and supported them to leave the room, which allowed the person to feel dignified.

An external healthcare professional told us, "I have found the relationships between the people and staff to be warm, with staff showing interest in engagement and responding appropriately. They added, "The people at Plean Dene are well presented and appear happy and settled." While another said external health professional said, "The staff are really caring."

Staff used different forms of communication to enable the people to understand and be involved in what they were doing. For example, one staff member used Makaton to assist the person to understand. Makaton is sign language used by people with learning difficulties. We also saw staff using visual aids to assist people to understand information and to make decisions for example when one staff member said, "What would you like to eat?" The staff member then showed the person some different options.

Although people required a high level of support, they were encouraged and supported to do as much for themselves as possible. One person was drinking from a cup, which they then knocked across the table, whilst giggling. The staff member supporting them said with humour, "Oh dear, that's not good, here we go are you going to help me clean it up." The staff member then got some kitchen towel and gave some to the person so they could both clean up the spill together. The person was smiling and laughing and put their hand out for more kitchen towel and the staff member said, "There we go, do you like helping, well done."

Staff were patient when speaking with people. We observed staff speaking with kindness and respect, sitting with people and chatting to them whilst supporting with activities. One person appeared to be enjoying some music that was playing in the lounge. A staff member said, "Is that alright, do you want me to turn it up? There we go is that better can you hear it better now?" The staff member then sang along to the songs that were playing and the person appeared to enjoy this interaction. Although people could not verbally communicate coherent conversations, staff members engaged them in everything that was happening in the home and asked about their days. A staff member said to someone who had arrived home after being out, "What did you do today, have you had a busy day? I heard you had sausage and chips."

Care plans and confidential documents were kept securely in lockable cabinets which staff could access. We saw staff respecting people's privacy and dignity by knocking on doors before entering rooms and closing doors when person care was being delivered.

Family were able to visit whenever they wanted to, although one told us, "I usually ring up to check if [person's name] is there as they go out a lot." Another said, "I can walk in any day and the staff always offer me a coffee and make me feel welcome."

Staff told us they enjoyed working at the home and one said, "Everyone's is so supportive and we try to help each other and make sure the residents get what they need." While another staff member said, "If I've got a problem I just ask and we all help each other, like sometimes [person's name] may not want me to support them and they make that clear through their behaviours, we just swap so that [person's name] is happy and we respect their choice."

Although we were told that no one had any specific cultural, religious or personal beliefs, public holidays and birthdays were celebrated with traditional foods and activities for people to participate in if they wished to. The home also had celebrations for Easter and Christmas where family and friends from the providers other homes were invited in to celebrate together, such as a party.

The registered manager was 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 people 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 registered manager knew where and when to contact them.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their individual needs. A family member told us, "The staff always give [person's name] the best of respect and they support them to do whatever they want." An external health professional told us, "I have found the staff really responsive, they have been fantastic with one person I work with and really took their time working through things together."

People had received initial assessments of their needs prior to moving into the home. This was so that the registered manager could be assured that they would be able to meet the needs of people. Following the initial assessment period care plans were developed which met their needs. As part of the initial assessment process, relatives were involved to ensure staff had an insight into people's personal history, their individual preferences and interests. Information of this type helps to ensure people receive consistent support and maintain their skills and independence levels. Copies of care plans were accessible to care staff should they need to refer to these.

Care plans contained clear guidelines which explained exactly how each person liked to be supported in different areas of their need. They included people's preferences, communication and personal support needs. They also detailed what support they needed to take their medicines and eating and drinking guidance. Records of the care and support delivered were maintained and showed people had been supported in accordance with their plans and their needs were met. Care plans contained detailed information about what was important to the person. For example, one care plan had details of what the person enjoyed and positive things about them. It stated, 'I love spending time in water and bathing is important to me; I'm affectionate and adventurous.' This showed that care plans were person centred and captured the individuality of each person. We spoke to staff who were aware of people's individual needs and what their abilities, likes and dislikes were and we saw these being followed during the inspection.

Care plans should be reviewed regularly and involve the person, their family or an advocate. We saw that care plans and related risks were reviewed regularly by staff to ensure they reflected people's changing needs. However, reviews had not always been regularly held with family members. One family member told us they did have regular conversations with staff and the registered manager and felt involved in their relative's care. We discussed reviews not regularly being held with family or advocates with the registered manager told us that reviews had now been scheduled with people's families to enable them to be consulted and involved in ongoing care planning for their relative. We saw that reviews had been held with family members recently for one or two people.

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. We saw new care plans that were being developed for people. These were photographic care plans that had pictures of all the things that were relevant to each person for their care and support. One person's photographic care plan had been completed and this was being used to assist them to be involved and to make choices. For example, it stated, 'I like to have my feet massaged' and 'I really don't like having my hair brushed.' There were

corresponding pictures next to these so that the person could understand what staff were offering them. This demonstrated that the home was working with a person-centred focus and were improving people's accessibility to information held about them. In addition, the registered manager had recently introduced 'twist and turn' care charts which were kept in each person's bedroom. The care chart was produced in a format that was visually accessible for people and was personalised with pictures of the person and photographs of their favourite things. This provided staff with a snap shot of each person's preferences and routines. The registered manager advised that this idea has also been shared with other care homes owned by the provider.

Person centred care is considered best practice and is a requirement of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providing support in this way meets each person's individual needs and enables them to maintain or develop new skills where possible. We saw staff involved people in decisions encouraging them to be involved in and choose what they wanted to do. For example, one person was encouraged to choose if they wanted to go bowling or for a picnic in the park and another person was supported to look at their rose bush that they had been growing in the garden to see if it had bloomed. We were also told that staff support people to access the kitchen and to make their own drinks when possible. The home has a special 'one touch' hot water machine so that people could be supported to make their own hot drinks with staff supervision. This demonstrates that the staff and manager actively promote person centred care for people and involve them in daily activities and choice about their own lives.

People's care plans contained detailed guidelines which described each person's communication needs and how staff should communicate with them. Where people were not able to verbally communicate, staff were able to demonstrate they understood people's needs and were following the guidelines. For example, staff responded to vocal noises that people made and spoke to them respectfully. Makaton was used regularly to reinforce the spoken word and objects were also used to assist people's understanding when making choices. Makaton is designed to support spoken language and uses signs and symbols to help people communicate. Staff asked people to show them what they wanted by going to the item, area or room the person may want. In addition, staff recognised that people also communicated through their behaviour and we saw staff were responsive to this. For example, when one person was making loud noise and appearing frustrated, staff immediately went to them and tried to work out what they were trying to communicate to them. Sometimes this was a process of elimination until they found out what the person wanted, but staff remained patient and calm throughout.

People were supported by staff to go into the community for activities. Some people had specific activities that they attended each week, while other activities were based on the choices of people each day. A family member said, "They often go out and have a picnic in the park, [person's name] is always out and about." We saw that people were offered the opportunity to go out to a local beach or shopping and were supported to do a variety of things that they enjoyed. We saw some people went out on the second day of the inspection to a local community singing group. The staff told us that this is run for any member of the public and the people who were attending that day had previously really enjoyed it. We were also told that there is a band stand in the local park which sometimes has music on. Staff supported people to attend these sorts of activities whenever possible and we saw in care records that people were getting out in their community on a regular basis. The home also held coffee mornings and celebration parties for people. People who lived in the providers other homes and family members were regularly invited to join in. We were told about a recent Easter party which had been held and that people had been involved in preparing for this and had enjoyed it very much. Staff spent time with people doing activities in the home and we saw staff singing along with people and supporting them to go into the garden and to help with tasks of daily living, which demonstrated active involvement in their lives and in the local community.

The registered manager had a clear understanding of the importance of not discriminating within the workplace and for the people living at the home. The provider had a clear process for action to be taken if any discrimination occurred. At the time of the inspection, there was no one living at the home with a specific religious or cultural background or requirement; however, the registered manager told us that they would make adequate provisions to respect this and would consult with the person's family and friends if they lacked capacity or were not able to verbally communicate.

The provider had a complaints procedure and the home had developed their own easy read complaints process. This used pictures and short simple sentences. However, not all the people who live at the home understood the easy read version or would be able to formally complain due to their learning difficulties. The registered manager told us that the home had only received one complaint in the last year, which was from a family member and was quickly resolved. A family member we spoke to said, "I can speak to the staff or the manager whenever I want to and they listen and we talk things through." We were told that if any complaints were received, they would be managed and recorded through the system that the provider had set up. We discussed with the registered manager the possibility of low-level concerns being raised by people or their families that could be used to develop the service and learn from past experiences. This information was not being captured and therefore the provider was unable to monitor themes or patterns. The registered manager was responsive to this and recognised that support for people living in the home when they might be unhappy about something but were unable to verbally complain, would be introduced.

Some staff had received end of life training to assist them to support people at the end of their life and to make plans for any arrangements they would want. However, this is a home for younger adults and therefore the registered manager told us that they would discuss end of life with people and their families when it was needed, and would record wishes in people's care plans. The registered manager told us that they had records for two people whose families had already expressed specific wishes.

Good

Is the service well-led?

Our findings

There was a registered manager in place who was responsible for the day-to-day running of the service. They had developed a positive relationship with the people who live at the home and their families. Staff spoke positively about the registered manager, one said "The manager is very good; you can always talk to them." While another said, "I find [registered manager] very approachable, they do a good job, I get all of the supervisions and training opportunities I need."

The provider had quality assurance processes in place which we found had not identified shortfalls in mandatory training, although the service continued to fully meet people's needs.

We recommend that the provider ensures it has systems in place to monitor the consistent delivery of mandatory training.

Care plans were person centred and had detailed information in about people's specific needs. The registered manager had been reviewing all care plans for people and we saw from audit records that there were plans in place for all people to have a photographic care plan which was specific to their needs and that would be used to enable greater involvement and choice.

The concerns we found were discussed with the registered manager during the course of the inspection. Each time we informed the registered manager of our findings of an area that required improvement, they were responsive and immediately set about resolving the issue. We were told that relevant best interest decisions would be in place for all people that required them.

Residents meetings were being held and we saw records that showed that people had been involved in choosing the colour of the new carpets that had been fitted and new opportunities for activities in the community had been suggested. For example, the possibility of people being able to volunteer at a local scout group had been discussed, summer barbeques and what local music events were coming up. The records of meetings were recorded using pictures and photographs as well as short sentences, this showed that staff were recording the meetings in a way that would be accessible to the people living at the home and staff told us they support people to understand what had been discussed using the visual references.

The registered manager told us that they were keen to promote and open and honest culture within the home and regularly spoke with staff members about this. They said, "I often have an informal, five minute chat with staff, I have nothing to hide." Staff told us that they enjoy working at the home and find that the staff team are all very supportive. One staff member said, "I love it here, the staff are great." While another said, "Everyone here is so supportive and helpful." We observed a positive culture throughout the inspection and saw that staff spoke to each other and the registered manager with kindness and respect.

Family members and external health professionals told us they that they felt the home was well-led. One external health professional told us the registered manager was approachable and worked with external health professionals in care planning and provision of support when needed. A family member told us, "I see

the manager occasionally and they tell me things that I need to know and what [person's name] has been doing." While another family member said, "I can walk in at any time and the manager is always available to talk to if I want to."

The provider had a business continuity plan which had been adapted to the specific needs of Plean Dene and this was reviewed yearly. The plan contained clear detail regarding the action to be taken in the event of specific incidents, such as a power supply outage. A service impact analysis had also been completed to provide emergency contact information, guidance on prioritising risks and support from other local homes in the event of an incident.

The registered manager told us that they stay up to date with important announcements and changes, and that they were signed up to a system used to issue public health messages, information and guidance, and safety alerts. The home also had regular contact with the provider's senior management team who provided internal and external updates, and with the providers other registered managers. This enabled the registered manager to share best practice and improve the service using other homes experiences.

The registered manager told us that they had recently linked in with another provider whose service has been rated as outstanding. This was so that positive ways of working could be shared and training provided for the registered manager and staff. As a result of the training, the registered manager had gained valuable information and ideas on how to improve the home and the support that people living there received. For example, they had looked at new ideas for increasing people's involvement in their own lives and making choices and this had led to the 'twist and turn' care charts being implemented.

The home used a visual representation to describe their vision and values and this was displayed on walls around the home. It described how each person should be treated as an individual with respect and be supported to try new experiences in a person-centred way. The registered manager also told us that the topic of promoting the values for the home had recently been discussed during a staff meeting, where staff were given the opportunity to write down what they felt were the key values of the service. The registered manager spoke about each staff member with respect and gratitude for the work they did within the home. They also explained that they had put forward individual staff members to be nominated for an upcoming staff awards ceremony to celebrate their hard work.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. These had been used to identify where action was needed and were either resolved immediately or if deemed non-urgent were identified on the provider's on-going action plan.
The registered manager arranged regular staff meetings which enabled them to update staff on any changes in policies, remind staff of their responsibilities, praise good practice and discuss any concerns about care provision. Staff meetings also provided staff with the opportunity to share ideas with the registered manager and talk about any concerns they may have. Staff told us they felt listened to and we saw that one member of staff had made suggestions which the manager was allowing them to try. This was using their own electronic device to improve entertainment and communication for people in the home.

People and their families were actively involved in developing the service and their views were sought through regular conversations with the registered manager and through questionnaires. Reviews of care plans were carried out monthly by staff that checked through people's care files; however, reviews were also planned with family members. Although one family member told us they didn't feel they were involved or asked for feedback, another said that they spoke to the manager whenever they wanted. The registered manager told us that they try to speak to people and their families regularly so their views can be sought and used to monitor and develop the service.

The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff were aware of the different external organisations they could contact if they felt their concerns would not be listened to.

The registered manager and staff team had worked to increase links with the local community and involve people in a variety of activities and events that were taking place. They recognised the importance of ensuring inclusivity for everyone living at the home. The registered manager and staff also linked in with events being held by other homes in the area, such as a Summer fete. In addition, the registered manager had contact with the local community to provide an opportunity for people living at the home to deliver the local parish newsletter and people were going to participate in a local festival being arranged by people with a learning disability. This demonstrated the efforts made to increase people's self-worth and sense of belonging in the local community.

There was an extensive index of policies and procedures in place, which were produced and updated by the provider's team. All policies were kept in a location that was accessible to staff, and the registered manager informed us that when new staff started at the home, they were given copies of the policies which they had to sign once read.

All services registered with the CQC must notify us about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had notified CQC about all incidents and events required.

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 February 2016, was prominently displayed at the home and there was a link to the CQC's rating on the provider's website.