United Response

Three Gates

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

The inspection visit took place on 16 and 18 May 2016. The service was last inspected on 3 December 2013, when all standards were met and no concerns identified. We gave the service 24 hours' notice of this inspection visit because we needed to be sure that the registered manager, staff and people would be in.

Three Gates is a small home which offers personal and social care for five adults with a learning disability (including autistic spectrum disorder). At the time of our inspection, four people were using the service.

The service had a registered manager. 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.

People were protected from the risk of abuse and avoidable harm. Their needs and risks associated with care were assessed and staff had clear guidance about how to meet people's individual needs. Care plans were regularly reviewed and updated to meet people's changing needs and preferences.

People were happy, comfortable and relaxed with staff. They were cared for by sufficient numbers of staff who were suitably skilled, experienced and knowledgeable about people's needs.

The provider took steps to ensure checks were undertaken to ensure that potential staff were suitable to work with people needing care. Staff received one-to-one supervision and had regular checks on their knowledge and skills. They also received regular training in a range of skills the provider felt necessary to meet the needs of people at the service.

The systems for managing medicines were safe, and staff worked in cooperation with health and social care professionals to ensure that people received appropriate care and treatment in a timely manner.

Appropriate arrangements were in place to assess whether people were able to consent to their care. The provider was meeting the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). This ensured that legal safeguards were in place to protect people who could not consent to aspects of their care.

People were supported to be as involved as possible in their care planning and delivery. The support people received was tailored to meet their individual needs, wishes and aspirations.

Systems were in place to monitor the quality of the service provided and ensure people received safe and effective care. These included seeking and responding to feedback from people and their relatives in relation to the standard of care. Regular checks were undertaken on all aspects of care provision and actions were taken to improve people's experience of care.

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.

People were protected from the risk of avoidable harm by staff who were trained and confident to recognise and report abuse. Medicines were stored, administered and managed safely. People were supported to take part in daily activities, and risks were identified and mitigated appropriately.

Is the service effective?

Good

The service was effective.

People received effective care from staff who had the knowledge and skills to meet their needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 to ensure that people's care was provided in the least restrictive way. People were supported to maintain their health care.

Is the service caring?

Good

The service was caring.

People were supported by staff who treated them with kindness, respect and good humour. People were involved in making decisions about their own lives as much as possible. Staff spent time establishing what people's wishes and preferences were, and providing support which was personalised.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated a good understanding of people's needs and preferences. People were supported to participate in activities and hobbies that were meaningful and enjoyable for them. A complaints procedure was in place and people were encouraged to express their views about their care and support.

Is the service well-led?

Good

The service was well-led.

Staff were aware of their responsibilities, and felt supported by the registered manager and their colleagues to provide good care. There was a positive and open culture, and staff demonstrated values including respect, kindness, honesty and a concern for people's well-being. There was an effective quality monitoring system in place to identify areas for improvement.

Three Gates

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 visit took place on 16 and 18 May 2016. We gave the service 24 hours' notice because people who live there are often out during the day. We needed to be sure that someone would be in.

The inspection team consisted of one inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example: a notification of serious injury or allegation of abuse. We spoke with local authority and health care commissioners who contract with the service to fund people's accommodation and care. We also spoke with Healthwatch Derbyshire, who are an independent organisation that represent people who use health and social care services. No concerns were raised by them about the care and support people received.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

None of the four people living at the service were able to fully express their views verbally about their care. We spent time observing how people were supported by staff during the two days of our visit. We spoke with four care staff, the team leader and the registered manager. We looked at two people's care records and a range of records relating to how the service was managed. These included three staff recruitment and training files, and the provider's system for checking the quality and safety of the service.

Good

Is the service safe?

Our findings

People were kept safe from the risk of avoidable harm by a staff team who understood how to support people safely. People were supported to watch a DVD on safeguarding that had been designed by the provider to be accessible and understandable. Staff knew how to identify people at risk of abuse. They could describe what indicators of abuse they needed to be aware of and knew how to report this. One staff member said, "We do safeguarding training, and we had a whistleblowing policy. I've never had to use these, but feel I could if needed, and feel confident I'll be listened to." Information on how to raise concerns was available for both staff and people in an accessible format. Staff were confident to raise concerns about abuse or suspected abuse. They also knew how to contact the local authority with concerns if this was needed, and the evidence we looked at supported this. Staff received training in safeguarding people from the risk of avoidable harm and this was recorded in training records we were shown. The provider investigated safeguarding concerns, accidents and incidents, and took appropriate action to ensure that people remained safe from the risk of avoidable harm.

People's care plans included relevant information about risks to their safety and how to protect people from the risk of avoidable harm. Staff understood how to support people to be as independent as possible, whilst ensuring that known risks were minimised. For example, one person was assessed as being at risk of developing pressure sores. They needed a pressure-relieving mattress, and pressure-relieving cushion for seating. These were in place. Staff needed to be trained in tissue viability to minimise the risk of the person developing pressure sores, and records showed that they were. This meant the person was supported in a way that minimised the risk of damage to their skin. We saw people being supported to transfer from their wheelchairs to sit in the car in a safe way, following the instructions in people's risk assessments and care plans. One person's care plan indicated that they needed additional support when bathing because they had epilepsy. Staff told us they needed to stay in the bathroom, but sit at a distance to give the person some privacy. They were clear that they did not leave the person alone in the bathroom in case they had an epileptic seizure. The care plan did not state where staff should be to monitor the person in the bath. We spoke with the registered manager about this, and they said they would update the care plan to ensure it was clear staff must stay in the bathroom.

There were plans in place to ensure people would continue to receive care in the event of an emergency. The provider had up to date and accessible personal emergency plans for everyone living at the location. These contained important information about how people needed to be supported in the event of an emergency, for example, if people needed to leave the building in the event of a fire or if people needed to go to hospital.

Accidents and incidents were recorded and reviewed by the registered manager, and action was taken to minimise the risk of future harm occurring. One person had a choking incident, and staff took immediate action to support the person and reduce risk. Records showed that staff had sought advice from the person's GP and from speech and language therapy. This resulted in their care plan being reviewed in relation to what food they could safely eat.

There were enough staff to provide the care people needed. Staff said they felt there was generally enough staff to support people in their daily lives. However, staff said there were occasions when there were not enough staff, for example, if staff called in sick. One staff member confirmed that they sometimes had to postpone some of their work to ensure that people continued to get the support they needed. Staff told us that staffing levels were flexible to enable people to be supported to go out. We saw that people were supported at times they wanted and needed this. For example, one person indicated that they wanted to go out to do a gardening activity and staff responded by supporting this to happen.

We saw during our visit that people had one to one support for activities when they needed this. People knew which staff were supporting them each day. Staff used an easy to understand pictorial plan for each day of the week, which staff used with people to show who would support them. The registered manager and team leader ensured that people were supported in activities by staff who had appropriate training, skills and enthusiasm for their activities. Staff confirmed they would support people with all their activities, but if people expressed a preference for particular staff to support them, then the rota would be adjusted so this happened. For example, people who regularly went swimming would be supported by staff who were confident swimmers and who enjoyed the activity. The registered manager told us, and records showed that people had this level of support every day.

The provider undertook pre-employment checks, which helped to ensure prospective staff were suitable to care for people. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This meant people and their relatives could be reassured that staff were of good character and were fit to carry out their work.

People's medicines were managed safely. Staff took time to explain to people what their medicines were for, and checked that people were happy to take their medicines. Staff had received training in the safe management of medicines and told us they felt they had sufficient training for this. Staff told us and records showed that they knew what action to take if a person missed their medicine for any reason. For example, we observed a weekly audit for one person's medicines carried out by a staff member. The person was present and staff involved them in the audit as much as possible. We saw that one error was identified where the person's prescribed medicine had not been signed for. The medicine was prescribed to be taken when needed, and it was unclear from the records whether the person had received the medicine or not. The staff member completed an incident form and reported this to the registered manager. The registered manager identified who had made the error and told us they would raise this with them. People's medicines were stored securely in their own bedrooms, which meant people were supported to have their medicines in private. We checked the storage and records staff kept in relation to medicines. These showed that medicines were stored, administered, managed and disposed of safely and in accordance with professional guidance.

Good

Is the service effective?

Our findings

People were supported by staff who were trained and experienced to provide their care. All staff had a probationary period before being employed permanently. The provider had a programme of induction which included role-specific training, shadowing experienced colleagues and skills checks by the team leader or registered manager. All staff undertook relevant training the provider felt essential to meet people's health and social care needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of nationally agreed care standards linked to values and behaviours that unregulated health and social care workers should adhere to. Staff told us, and records showed they had received an induction when they started work, which they felt was sufficient to be able to provide care for people. One staff member was on their induction period and we saw them work with an experienced colleague to learn how people needed to be supported. For example, experienced staff supported a person to have their breakfast and medicines. They explained what they were doing and why, and included the person in the process so that they could show the new member of staff how the person liked to be supported.

There were regular staff meetings which enabled staff to discuss information relating to people's care. Staff also had individual meetings with their supervisor throughout the year to discuss their work performance, training and development. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues. Staff said they undertook regular training in a range of areas the provider considered essential, including first aid, safeguarding, and medicines management. One staff member said, "I get a lot of training, which is good." Another staff member said the training was a mix of online learning and face-to-face training, and records confirmed this. Staff could request training that related to the specific health needs of people living at the service, such as medicine administration for epilepsy seizures. Records confirmed staff undertook this training annually. Staff told us and records showed that the registered manager did regular unannounced checks on staff members' skills and staff received regular refresher training in care skills. This showed the registered manager ensured that staff maintained the level of skills the provider felt essential to good quality care.

Staff were knowledgeable about people's individual care needs. They were also familiar with how people liked to be supported and what was important to them. For example, one person indicated to staff that they needed support. The staff member quickly identified what the person needed support with, and assisted them with personal care. We saw the person's communication styles were detailed in their care plan, and the staff member had interpreted their communication correctly and responded appropriately. Staff were able to describe what people's care needs were, and how people preferred to be supported. The care records we saw confirmed this.

Staff understood and followed the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive

care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People were assessed in relation to their capacity to make decisions about their care. Where they were able to make their own decisions, their care plans clearly recorded this. Where people lacked capacity to make certain decisions, the provider followed the principles of the MCA and ensured that best interest decisions were made lawfully. Staff had a good understanding of the practical application of the principles of the MCA, including how to support people to make their own decisions. One staff member said, "We will do as much preparation and communication as possible to help people make their own choices. This meant people's rights were being upheld and any restrictions in people's care were lawful.

The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant supervisory bodies appropriately. At the time of our visit, three people were subject to a DOLS authorisation. We saw that people's support was developed and reviewed in accordance with the principle of least restrictive practice. For example, one person wore a special body suit at night to prevent them pulling at their catheter. During the day, the person did not wear the body suit as staff were available to divert them from this activity. There was a risk assessment and care plan in place which showed that staff were using the principles of the MCA and minimising the risk of avoidable harm. People subject to a DOLS authorisation had a relevant person's representative (RPR) as required by law. One person's RPR confirmed they visited regularly and they had no concerns about people's care. This meant people's rights were being upheld and restrictions in people's care were lawful.

People were supported to maintain a balanced diet. Staff were familiar with people's food and drink preferences and people had access to the kitchen throughout the day. Staff supported people to participate in meal preparation, and people were given support to make drinks and snacks when they wished. For example, one person was supported to prepare their lunch by staff who gave lots of encouragement and guidance. We saw staff ensured that the person cut ingredients into bite size pieces. People were involved in meal shopping and planning, and chose when they wanted to have their meals. Staff recorded what people's daily food and drink choices were, and this was reviewed to ensure that people were having sufficient amounts and a variety of food. Two people were assessed as being at risk from choking, and we saw that staff followed the guidance given to them by healthcare professionals.

People were supported to maintain their health and to access health services when needed. People's care plans identified what their health needs were and how staff should support them. Staff kept daily notes regarding any health concerns for people and action taken. People's health and social care appointments were recorded and we saw that where medical advice was recorded by staff, this was then followed up if action needed to be taken. For example, one person was admitted to hospital in February 2016, and subsequently had an outpatient's appointment. Staff recorded what happened and what medical advice the person was given. This meant that people were supported to monitor their health and access external health professionals when required.

The provider had ensured people and external health professionals had key information available in the event of a hospital admission. People had a hospital passport document which summarised their health conditions and medicines. This plan had clear information about how people needed to be supported and how they communicated. This meant when people needed to go to hospital, health professionals had information about how to support them appropriately.

Good

Is the service caring?

Our findings

People were supported by dedicated and compassionate staff who understood their needs and preferences for care. We saw staff supported people in a relaxed and caring manner during our visit. A lot of interaction between people and staff was good humoured; people used smiles and laughter to indicate they were happy and felt comfortable with their care. When people indicated they wanted something, staff responded in a timely manner, and demonstrated kindness and respect in the way they spoke with people throughout the day. People were supported by staff to answer the door whenever anyone visited during our inspection visit. Staff explained they encouraged people to do this as this was their home, rather than the staff's workplace.

The registered manager and staff demonstrated their commitment to supporting people with care and compassion. Staff described how people were encouraged to make as many choices as possible about their daily living. We saw people were treated as individuals and were enabled to be as independent as possible. The provider's staff training and care policies emphasised active support. Staff described this as a way of supporting people to do things for themselves as much as possible and facilitating independence and we saw that this happened throughout our inspection visit. For example, we observed people being supported to prepare their meals by staff who provided lots of encouragement and hand over hand support to ensure people were involved.

Each person had a keyworker who was responsible for overseeing planning and reviewing people's care. Staff spent time with people each week reviewing how the week had gone, and we saw staff tried to establish whether activities and care over the week had been a positive experience. Staff told us and records showed that care plans included a lot of step-by-step detail to guide them on providing care in ways people wished. We also saw care records and other evidence in the house celebrated people's achievements and key milestones in their lives. For example, one person had a large photograph in their bedroom showing them laughing with staff during a holiday activity.

People were offered choices about their daily activities. Staff had developed weekly activity plans with people that reflected their known preferences. For example, one person enjoyed horse riding and records showed they had been supported to do this regularly. Staff said the plans would change depending on what people wanted to do and how they were feeling. Records confirmed that this was the case. One staff member said they worked on providing people with active support to help them increase their confidence and skills. The staff member described one person as having, "Gone from passive to making more choices. For example, they will open the car door themselves, they won't just sit and wait for staff." Our observation of the person accessing the car supported this. Staff supported people to make decisions about what they wanted to do. This showed that people's daily living activities were planned to accommodate their personal choices and people were supported to be more independent.

People's activity plans and other key information was designed to be accessible to people. For example, activity plans had pictures and clear short words to help staff communicate with people about daily choices. This meant people understood what was being offered and were supported to make their own decisions.

Staff told us, and records showed, that people were supported to express their views and wishes about their daily lives. People's care plans showed that, where possible, people's preferences about how they were supported were documented. As people had limited verbal communication, people's care plans showed staff how their non-verbal communication and behaviour indicated their wishes and preferences. Records contained information about people's communication styles, and we saw staff understood and used this guidance. For example, one person's care plan recorded different actions they did to tell staff they wanted something. This person's records also had clear information about what their actions might mean, which gave staff guidance on how to support the person.

Each person had a 'hospital communication passport' for use in the event of their hospital admission. This provided essential information for hospital staff about how to communicate with the person and how they liked to be supported. This meant hospital staff would be able to provide healthcare in a way which respected people's individual choices and preferences. Staff were aware of how to refer people to advocacy services, and we saw that people had been supported by advocates when needed.

People were supported to maintain their personal appearance and to receive care in a manner which was dignified and respected their privacy. Staff understood the importance of supporting people with their personal care in a dignified way. On our inspection visit we observed staff always ensured that toilet doors were locked when providing support, and ensured people's clothing was properly adjusted afterwards, to promote their dignity.

People's medicines and care records were stored securely in their rooms. Staff understood how to keep information about people's care confidential. We saw staff speaking with each other and with people about care needs in a way that was respectful of people's confidentiality. For example, we observed staff supporting a person to take their medicine in their bedroom. Staff ensured that they closed the door to maintain the person's privacy.

Good

Is the service responsive?

Our findings

Staff were responsive to people's needs. People using the service had variable levels of verbal communication, so staff used "learning logs" to record daily activities. This gave staff information about how people had responded, what worked well and any areas of concern. The learning logs enabled staff to assess and tailor people's care based on the activities they enjoyed, at times that suited them. For example, one person was supported to attend a local disco, but their behaviour indicated they did not enjoy the experience. Staff supported the person to leave the disco early, which made them happier. The learning logs helped staff evaluate the outcome of activities, and enabled them to offer people new activities to try, based on their responses to experiences. This ensured people's individual preferences were known and respected, and positive experiences were promoted.

People's care plans contained detailed personal information about what they liked and disliked, and what aspects of their care worked or did not work for them. Individual preferences and choices were also recorded, and staff were knowledgeable about these. One staff member spoke about a weekly 'Equality and Diversity' group session, which they facilitated. This took place at the provider's day service, and involved activities exploring different countries and cultures. The staff member said they supported people to try new experiences, for example, different foods, music and art activities. They said, "It's good to really learn about people. I've discovered [this person] really likes peanut butter smoothies, but [another person] doesn't like spicy food."

Individual care plans contained information about people's health and social care needs, and recorded which professionals were involved in supporting them to maintain their health and well-being. Care plans were written in the first person, providing an individualised profile for each person. People's choices and preferences were recorded, which enabled staff to provide personalised care and support. People's future goals and information about 'What is important to me and 'What is important for me' had been established and recorded. For example, "When I have finished washing ask me if I want a soak in the bath" (Important to me). "If I choose to have a soak leave me but stay close by in case I need you." (Important for me). Care plans also included information about people's interests, likes and dislikes, food preferences and preferred personal care routines.

People were supported to take part in activities that they chose and enjoyed, both within the home and out in the local community. During our visit, all four people at Three Gates were out doing different activities at various times throughout the day. Staff told us and records showed that people were regularly supported to go out during the week to participate in a range of activities they enjoyed.

People's care plans contained detailed information about their individual communication styles and how staff needed to respond. One person's communication guide said, "I need you to be aware I cannot tell you verbally that I am feeling unwell, so I need you to notice changes in my behaviour." There was detailed information about the person's different ways of communicating, and examples of what might indicate that the person was feeling unwell. Staff we spoke with were knowledgeable about the person's non-verbal communication and how they should respond. This meant people were supported by staff who understood

them well, and who knew how to identify that people may be unwell or unhappy with an aspect of their care.

Records showed that people's support was reviewed regularly, and staff updated care plans based on what was working or not working for people. For example, one person's care plan for support with eating and drinking was reviewed and updated following an assessment from speech and language therapy, which had made recommendations for foods to avoid to prevent the risk of choking. This showed the provider involved people in planning, reviewing and tailoring their care to their individual needs and preferences.

People's views about their care were gathered in a variety of ways at Three Gates. The registered manager told us that people and staff reviewed how each week had gone, and staff used the information from this and the daily records to identify issues or concerns. People and staff also had a monthly house meeting to discuss future plans and what was working and not working for people. Evidence we looked at demonstrated that where people or staff identified areas for improvement, action was taken.

Staff were familiar with the provider's complaints procedure and felt confident to support people to raise concerns or make a complaint. Information was available in accessible formats around the service to let people know how to do this. There was an easy to understand pictorial complaints procedure and people were supported to watch a short film clip about how to raise concerns or make a complaint. The provider had a policy which set out how concerns or complaints should be managed and what to expect, and this was also available in an easy to read format. We saw that there had been no complaints since our last inspection.

Good

Is the service well-led?

Our findings

People were supported to have active lives in their local community. Staff told us and records showed that people went out most days of the week to do things they wanted to do. Staff told us they felt confident to support people to try new experiences, as there was support in place to ensure that they could assess and minimise risks, and ways they could identify how people responded to new experiences. One staff member commented, "Staff have a 'can-do" or 'how can we' attitude, not a 'can't do' attitude."

Staff understood their roles and responsibilities, and demonstrated they were trained and supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. Statements must describe, for example, the provider's aims and objectives in providing the service. United Response's statement of purpose states that, "We will do all that we can to ensure that we are able to understand how the people we support communicate, and focus on listening to what people say, through their words and behaviour, to find out what they want to do, what their aspirations are, and how they can be fulfilled." The registered manager and staff showed us they worked with the people they supported to enable them to communicate their needs and wishes, and to support them to lead active and meaningful lives.

Staff spoke positively about the support they received from the registered manager and from each other. They felt confident to raise concerns or suggest improvements. One staff member said, "I feel supported and listened to." We saw one member of staff challenged the registered manager, to let them know how to support a person in accordance with their assessed needs and wishes. This demonstrated that staff were confident to identify care that did not meet people's needs and raise this with colleagues to ensure people received safe care.

The registered manager understood their responsibilities and felt supported by the provider to deliver good care to people. We saw they appropriately notified the Care Quality Commission of any significant events as they are legally required to do. They had also notified other relevant agencies of incidents and events when required. The registered manager had taken appropriate and timely action to protect people and had ensured they received necessary care, support, or treatment. They also monitored and reviewed accidents and incident, which allowed them to identify trends and take appropriate action to minimise the risk of reoccurrence. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed.

There were systems in place to monitor and review the quality of the service. The registered manager and provider carried out regular checks of the quality and safety of people's care. This included monitoring people's care and how they felt about this and regularly seeking people's views about the service. They also investigated where care had been below the standards expected and took steps to improve people's care. They undertook essential monitoring, maintenance and upgrading of the home environment. Improvements were made from this when required. For example, recent guidance had been given to staff about clear record keeping and the importance of demonstrating that care was given in the least restrictive

way possible. The registered manager told us that improvements were being made to people's care plans through the use of standardised documentation to help staff record information about people's care in a consistent way.

The provider had a range of organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these and they were knowledgeable about key policies that supported them to provide safe care. For example, medicines, communication, complaints, and safeguarding. We looked at a sample of policies and saw these were up to date and reflected nationally recognised guidance and practice standards. The provider's whistleblowing policy supported staff to question and report any unsafe or abusive practice. Staff confirmed that if they had any concerns relating to people's care and safety, they would report them and felt confident the registered manager would take appropriate action. This demonstrated an open and inclusive culture within the service.