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

Plean Dene is a care home run by the local authority, which provides accommodation for up to 13 people who have a learning disability. At the time of our inspection there were nine people living in the home.

The inspection was unannounced and was carried out on 09 and 11 February 2016.

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

The families of people living at the home told us they felt their relatives were safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided enough information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received the appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

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

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain their family relationships.

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

People who were not able to communicate verbally showed that they understood and they made their wishes known to staff. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when speaking with people, who used a variety of signs, noises and body language to express themselves. Staff were able to understand people and

respond to what was being said.

People's families were involved in discussions about their care planning, which reflected their assessed needs. Each person had an allocated keyworker, who provided a focal point for that person and maintained contact with the important people in their lives.

There was an opportunity for families to become involved in developing the service and were encouraged to provide feedback on the service provided. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

The registered manager had assessed individual risks to people. They had taken action to minimise the likelihood of harm in the least restrictive way.

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

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

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

Is the service effective?

Good

The service was effective.

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

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and ongoing training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

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

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

People were allocated a keyworker who provided a focal point for their care and support.

The registered manager sought feedback from people, their families and health professionals and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

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

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

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

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 checked 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 09 and 11 February 2016. The inspection team consisted of an inspector and a specialist advisor. The specialist advisor was someone who had experience and knowledge of working in the field of supporting people with learning disabilities.

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

We engaged with four people staying at the home, who communicated with us verbally in a limited way, we spoke with three relatives and a friend of one of the people. We observed care and support being delivered in communal areas. 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 three members of care staff, two senior care staff, the cook, the registered manager and with the group manager on behalf of the provider. We also received feedback about the service from a social care practitioner and an advocate.

We looked at care plans and associated records for five people using the service, staff duty records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in November 2013 when it was compliant.

Good

Is the service safe?

Our findings

The people we engaged with indicated they felt safe. The families and a friend of people using the service told us they did not have any concerns regarding people's safety. One family member told us the staff monitor who comes into the home to keep people safe. They said, "even I can't get in the house without someone letting me in". They added "When [my relative] is outside they [staff] are always monitoring them". A friend of one person said, "I have absolutely no concerns. There is always someone around. No one is left on their own". A social care practitioner told us they did not have any concerns regarding the safety of people living at the home and an advocate said they home was reacted to safety concerns and took action to limit the risks.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people. All of the staff and the manager had received safeguarding training and the staff knew what they would do if concerns were raised or observed in line with the providers' policy. One member of staff told us if they had any concerns, "I would notify my senior, then my manager and if no joy then CQC". The registered manager explained the action they would take when a safeguarding concern was raised with her and the records confirmed this action had been taken when a safeguarding concern had been identified. The registered manager had reported this to the appropriate authority in a timely manner.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person had a protection plan which identified triggers in respect of their behaviour and the distraction techniques staff could use to help the person manager their behaviour. During our inspection we observed staff monitoring the person and intervening when appropriate with distraction techniques in line with their care plan and allowing them to remain engaged in activities and with the other people in the home. A family member told us, "Staff understand [my relative's] risks. There have been a number of incidents over the years, so they know what the risks are and how to manage them". A member of staff said, "If a service user had an accident I would fill in a body chart, informing the senior of the need to do a risk assessment for the service user to prevent it happening again, update the care plan and write in the handover to monitor overnight".

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record of this, which was sent to the provider. This enabled analysis to take place both from the home's perspective but also provided the opportunity for learning and risk identification across all of the services owned by the provider. Each person's care plan contained a 'Vulnerable Adult Form', which provided the information necessary for health professionals to support that person should they be taken to hospital in an emergency.

People's families told us there were sufficient staff to meet this relative's needs. A friend of one person said,

"People are never left on their own. Staff always answer the door quickly when I knock". A family member told us "There is always someone around in the dining room or lounge wherever the residents are". Another family member told us there was "ample staff available when I have visited. I pop in at different times and staff are often sitting with residents, talking with them".

The registered manager told us that staffing levels were based on the needs of the people using the service. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people promptly and additional staff members were available to support people attending activities away from the home, for example, visiting a local day centre, going shopping and swimming. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff employed by the provider at other homes, the provider's bank staff and agency staff. The registered manager was also available to provide support when appropriate.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks, were completed for all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager had also started to review the DBS checks annually to identify whether staff circumstances had changed.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed to ensure their practice was safe. However, we did identify some inconsistencies in respect of staff completing the medicines administration records (MAR) correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm a person had received their medicine. We identified six occasions where medicines had been given but the MAR chart had not been initialled. The medicines formed part of a pre-packaged dosage blister pack and on each occasion the other medicine in the blister pack had initialled as being given. We pointed this out to the registered manager who agreed it was an area for improvement and took action to prevent the omission reoccurring.

Where people were prescribed medicines 'as required', there was clear written information in place for staff to understand when these should be given. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were appropriate plans in case of an emergency situation. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary. Evacuation Ski sheets, which are an aid to assist staff to evacuate people with limited mobility in an emergency were also available for each person.

Good

Is the service effective?

Our findings

The families and a friend of people using the service told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One family member said, "I have thought it for a long while, they [staff] know [my relative] well and know what they like to do". A friend told us their friend had, "been there a long time, so they [staff] know them and how to look after them". A social care practitioner told us the staff were knowledgeable about people and an advocate said the thought people were supported quite well.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. People were also supported by an independent advocate or an independent mental capacity advocate (IMCA), when appropriate, for important decisions that affects their lives. For example, when considering a best interest decision to deprive a person of their liberty.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made by the supervisory body with the relevant authority for all of the people using the service. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option. For example, in order to support one person to maintain their independence and interact with the community, they provided with a mobile phone that has the ability to track their location. This option was subject to a best interest decision and a DoLS authorisation.

Families told us that staff asked their relatives for their consent when they were supporting them. One family member said their relative "will make their feelings known if they don't want to do something". Another family member told us their relative "knows their own mind and won't do something they don't want to do". Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. One member of staff told us, "I will always ask the resident what they would like to do and if they would like me to help them". Daily records of care showed that where people declined care this was respected.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on "Skills for Care Common Induction Standards" (CIS). CIS are the standards employees working in adult social care should meet before they can safely work unsupervised. New staff who were recruited after April 2015, received an induction and training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager had arranged for all staff to undertake the care certificate training as a way of refreshing their knowledge and a means to encourage discussion within the team.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults and first aid. Staff had access to other training focused on the specific needs of people using the service. For example, epilepsy awareness, autism and dementia awareness, down syndrome awareness, training in respect of the new care regulations and the provision of end of life care. Staff were supported to undertake a vocational qualification in care. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the registered manager and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us "I have regular supervisions, every three months, where I can raise any concerns, request training or discuss other things such as problems with other staff".

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person told us "my soup is lovely". Another person said the cook had made her, "a birthday cake" and added the food was "nice". Family members were complimentary about the food and told us their relatives were supported to eat the food they liked. Comments included "The food is very good, [my relative] likes soft food. Staff know exactly what he likes and how [my relative] likes it prepared" and "[my relative] really enjoys their food". One relative said their relative, "sometimes likes to cook for themselves", which they were able to do with support from staff. The cook was aware of people's likes and dislikes, allergies and preferences. People were offered a choice of food and an alternative was offered if they did not want what was offered. During lunch one person was offered the chance to taste a pasta dish and when they didn't like it they were invited to go to the kitchen to choose a sandwich filling. They were subsequently offered a second sandwich if they were still hungry. As it was Shrove Tuesday, people were offered a choice of pancakes or an alternative dessert. Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff having their meals asked to join people at their table and chatted with them. Staff were aware of people's needs and offered support when appropriate.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. Family members and a friend of one of the people told us they did not have any concerns over the level of care provided or how it was delivered. One family member said "Staff do a fantastic job engaging with them. As I said the home is a utopia". Another family member told us, "Staff are very caring and treat each [person] as an individual". A friend said staff were "very patient, very caring. They know all of the residents really well".

People were cared for with dignity and respect. Staff spoke to people with kindness and warmth and were observed laughing and joking with them. As a member of staff entered the dining area a person said something to them which they didn't hear. They stopped what they were doing and went over to the person, crouched down so they were at the same level as the person and asked them in a quiet voice to repeat their question. On another occasion one person was sat at the table doing some colouring. A member of staff engaged with this person and asked "Do you mind if I help you"? The person agreed and the member of staff asked "What colour shall I do"? On a different occasion a member of staff ask a person supported a person to move the chair. They checked it was what they wanted and then explained what they were doing so the person was not surprised by the movement.
The home had a dignity champion whose role included making sure dignity and respect is at the heart of everyday practice. We spoke with the dignity champion who told us they lead by example. They explained they supported people to ensure they were dressed appropriate for the time of year and in a way that ensured their dignity was respected. They said, "I ensure they have quiet times when requested and support them in the community". Staff responded promptly to people who required assistance. A person sitting in the dining area told staff they felt too hot. Staff asked them if they would like to move to the lounge, which would be cooler. They did and the staff supported the person to mobilise and helped them into the lounge.

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. A family member told us they were unhappy sometimes with the choice of clothes their relative wore. They had raised this with staff, who told them these were their relative's choice as they went to the drawer and pulled out what they wanted to wear. Staff made sure the items of clothing was suitable for the time of year and activities being carried out. Another family member said their relative, "sometimes likes to go to bed during the day and they [the staff] don't stop her". A friend said "I have no problems there [the home], if we want to have a private chat we can. Staff are always very polite".

Choices were offered in line with people's care plans and preferred communication style. One member of staff was communicating with a person asking them if they would like to go to the film club. The person replied with a loud bang on the table, which indicated yes. Where people declined to take part in an activity or wanted an alternative this was respected. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. On one occasion a member of staff spoke discreetly with a person to check whether they needed support with their personal care needs. Another member of staff told us that when supporting people, "I always make sure the windows are closed

and curtains drawn for personal care, close doors and cover the resident appropriately with a towel. It is all about their human rights and choice too".

When appropriate, people's families were involved in discussions about developing their care plans, which were centred on the person as an individual. We saw that people's care plans contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes.

People were encouraged to be as independent as possible. One person was supported to be independent in the community and was able to leave the home when they wanted to. Staff had supported them to obtain a Local authority 'Autism card' which he could use to inform the public, if they needed to explain their actions and could not do so in an effective manner. As part of a best interest decision, the registered manager had also arranged for a means of tracking the person's location should they become lost or confused. Other examples of people being encouraged to be independent included, staff patiently encouraging a person to mobilise out of their chair by themselves and domestic tasks such as taken they crockery to the kitchen after lunch or putting their rubbish in the waste bin. Staff praised their efforts and we saw the person's face reflected a sense of achievement. One family member told us staff were, "trying very hard to help [my relative] become more independent".

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. One family member said that staff supported their relative to, "come over each week to see us". People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Good

Is the service responsive?

Our findings

People, their families and a friend of a person using the service told us they felt the staff were responsive to their needs or the needs of their relative. One family member said their relative, "has been here for a long time and as [their] needs have changed we discuss it with staff". Another family member told us, "They [staff] are very good they always keep me up to date with what is happening with [my relative]". A friend said, "The staff are absolutely fantastic. They seem to understand [my friend] and her different moods and how to look after her".

Those people who were not able to verbally communicate with staff, were able to demonstrate their understanding what they were being asked and could make their wishes known. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond.

When appropriate, people's families were involved in discussions about their care planning, which reflected their assessed needs. One family member told us, "We are naturally concerned about [my relative's] future so although we try and stand back to allow them to be independent, we do get involved in their reviews".

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff understanding of the care people required was enhanced through the use of support plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. Each person had an 'easy read' health action plan supported by pictorial representations suitable for the needs of the person they related to. Where possible, this was used to encourage people to become involved in developing the care plan.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift and supported by a communication book, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room. Each of the key workers carried out a monthly review with the person of the activities they had engaged with and the activities they might like to try. They discussed their health needs and asked for the person's views about their support. A family member told us their relative's keyworkers were "really on the ball. They seem to understand just what she wants".

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. For example, one person had stated they want to go to film club and arrangements

were made for him to go. At the last minute they changed their mind and asked to go to a café for "a cup of tea and some coffee cake" which this was arranged instead. People had access to activities that were important to them. These included attendance at day centres, swimming, bowling, film club, drives around the island and shopping. We saw that arrangements had been made to support a person to go horse riding. A family member told us their relative had "plenty of things to do". Another family member said staff "are trying to get [my relative] out when they can".

There were activities available for people in the home, such as helping with domestic duties like cleaning or washing up, aromatherapy sessions and listening to music. A friend of one person told us, "there are always plenty of things organised for [my friend] to do. They love doing the jigsaws, craft work and going out".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. People were supported by advocates and independent mental capacity advocates (IMCAs) who were available to support them if they were unhappy about the service provided. The IMCAs had been involved in supporting people with the decision to apply for authorisations under the deprivation of liberties safeguards (DoLS). The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. A family member told us "Whenever I speak with the manager she is always asking me if I am happy with what is happening with [my relative]". The registered manager also sought formal feedback through the use of quality assurance survey questionnaires send to people's families and health professionals. We looked at the feedback from the latest survey which was all positive and included comments from health professionals commending the service. Feedback from family members included "staff are fantastic", "I am very impressed with the way [my relative] is cared for" and "My relative] is very happy there".

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The registered manager told us that people's keyworkers would support them to raise any complaints initially and people also had access to independent advocacy services if they needed them. All of the family members knew how to complain but told us they had never needed to. The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received.

Good

Is the service well-led?

Our findings

The families and a friend of people using the service told us they felt the service was well-led. They also said they would recommend the home to their families and friends. One family member said the registered manager was, "more than approachable. I have sat and chatted to her many times. She has helped me with the bereavement of my wife". A friend of one person told us "I definitely think it [the home] is well-led. It always seems well organised when I visit".

There was a clear management structure which consisted of a registered manager, senior care staff and learning disabilities group manager. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us "If I have any problems or concerns, I know who to go to and know the [management] ladder if I am not happy with the result".

Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said "I am fully supported by my manager and she is always supportive especially recently around some [personal] issues I have". Other comments from staff included "We have a good team here" and "Yes, I feel very engaged in the running of the home. We talk about things all of the time. [The registered manager] is very approachable".

Family members told us they were given the opportunity to provide feedback about the culture and development of the home and all said they were happy with the service provided.

The provider had suitable arrangements in place to support the registered manager, through the group manager. They were also able to raise concerns and discuss issues with the registered managers of the other learning disabilities services owned by the provider. There were systems in place to monitor the quality and safety of the service provided and the maintenance of the buildings and equipment. The registered manager carried out regular checks of medicines management, the cleanliness of the home, and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. The registered manager told us that if a concern was identified remedial action would be taken.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The provider and the registered manager understood their responsibilities and the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration.