CRW Consultancy Ltd

Kings Hill

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kings Hill is a domiciliary care service providing personal care to people in their own homes. At the time of the inspection there were four people receiving personal care. This included older people and people with a learning disability. Care and support hours varied from a few hours a week to 24 hours a day. Care and support were provided in West Kent and Medway.

CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Staff did not always have access to information about people's past history which helps to provide person-centred care. It was not clear who was managing the service as there was no registered manager in post. There were no checks on the care and treatment provided to one person who was not always able to express themselves clearly.

People's experience of using this service
There continued to be widespread shortfalls in the way the service was led as the provider did not have full oversight of the service. There continued to be no registered manager, the nominated individual was absent, and it was unclear who was managing the service in their absence. A positive culture was not consistently promoted throughout the service.

We raised a safeguarding with the local authority before the inspection visit as we were unable to contact the provider or anyone else at the agency for four days.

Quality monitoring systems continued to be insufficient to identify shortfalls and drive continuous improvement in the service. Shortfalls in risk management, records, medicines and providing person-centred care continued at this inspection. In addition, we found shortfalls in staffing and staff recruitment.

Staff who worked alone were not regularly checked to make sure they had the skills necessary for their role to provide a satisfactory standard of care. Records about people's care were not audited to ensure staff responded appropriately to people's changing needs. People's records were not always available to staff.

People were at potential risk of harm as there continued to be a limited approach to assessing and acting on risks to people's safety. This included not identifying potential hazards at people's homes, and not acting to

minimise risks when they had been identified.

Staff training records showed staff were up to date with all mandatory training. However, it was not possible to concur all staff had been trained as there was not a definitive list of staff who supported people. The provider had not regularly checked medicines records or staff's competency in administrating medicines.

Some staff had started to support people unsupervised, before their suitability to work with vulnerable people had been checked.

The views of people, relatives, staff and health and social care professionals had not been actively sought to make improvements to the service.

Feedback from a relative was that they would recommend the service and the provider responded when they contacted them.
Staff knew people well and said that the staff team worked well together. They said other team members and the provider was easily contactable for advice and support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 11 May 2020). The provider had sent us an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection not enough improvement had not been made and the provider was still in breach of multiple regulations.

Why we inspected
We carried out an announced inspection of this service on 1 February 2021. This was a focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe, Responsive and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kings Hill on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to quality monitoring, assessing risk, medicines, providing personalised care, records, staffing levels, staff recruitment, protecting people from harm and changes to the provider's registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Kings Hill

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Kings Hill is a domiciliary care agency. It provides personal care to people living in their own houses and flats. Kings Hill is also a supported living service. It provides care and support to people living in two supported living settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had not had a manager who was registered with the Care Quality Commission since June 2018. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service four days' notice of the inspection. The provider was unresponsive to our contact and we needed to be sure that the provider was available to gain entry to the office.

What we did
We reviewed information we had received about the service since the last inspection. We did not ask the provider to complete a Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
Inspection activity started on 1 February and ended on 4 February. We visited the office location on 1 February. We spoke with five staff including the provider, a senior carer and three care staff. We also spoke with one person's relative.

We reviewed a range of records. This included four peoples care files and two people's medication records and daily notes. We looked at three staff files in relation to recruitment and staff supervision. We also saw a variety of records relating to the management of the service. This included the staff training record and quality checks and audits.

After the inspection
The provider said they would send one person's daily notes and arrange for us to speak to two relatives. However, the provider has not sent us this information since the inspection visit.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to safely manage risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

- There continued to be a limited approach to assessing potential risks. Shortfalls identified at the last inspection had been addressed, but we found additional areas of potential risk.
- It was recorded in one person's daily notes that in January 2021 they had been 'aggressive' and 'self-harmed' on a number of occasions. This person's care plan had been reviewed at the start of February 2021. However, there was no guidance for staff as to what may trigger these behaviours or how to best support the person to keep them and staff safe.
with a naked flame, the resulting fire burns quickly and intensely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection the provider had failed to ensure there were safe and consistent systems for the management of medicines which put people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

- Medicine practices continued to be inconsistent and it was not always clear what the providers roles and responsibilities were with regards to the management of people's medicines.
- We could not be assured all staff that supported people with their medicines had the skills and knowledge to do so, as the provider did not have an accurate list of staff who supported people.
- The provider's policy was that staff had medicines awareness training every two years. In addition, their competency was assessed by a senior staff member every six months to ensure they had the skills and knowledge to manage people's medicines. These competency checks had not been undertaken at the last

inspection. The provider told us these records were available in people's homes. However, we only received a competency check for one staff member. Senior staff had still not completed medicines training at a higher level so the provider could be assured they had the skills to undertake this role.
● Records setting out the provider's responsibilities for managing people's medicines were contradictory. One person's risk assessment said the agency was responsible for ordering their medicines only. But their care plan stated that staff administered their medicines. The provider did not show us this person's records when we asked. This meant they were not able to provide evidence the person was receiving their medicines safely.
●The provider had not assessed the potential fire risk when using emollients. An emollient was used to treat one person's dry skin condition. When fabric with dried-on emollient comes into contact with a naked flame, the resulting fire burns quickly and intensely.

There were not safe and consistent systems for the management of medicines which put people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At our last inspection the provider had failed to identify and monitor significant events with regards to people's health and safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● Safety concerns continued not to be identified so it could not be assured action had been taken to keep people safe.
● The provider told us there had been no incidents or accidents since the last inspection. However, it was recorded one person with complex needs had fallen on 22 December 2020 and sustained minor bruising. The provider told us they were not aware of the incident. This person had also sustained a small cut to their upper lip on 16 January. No accident or incident form had been completed so the provider had oversight. There was no record that medical treatment or advice had been sought as a direct consequence of these accidents to ensure the person's health and well-being.
● There continued to be inconsistent monitoring of staff practice to ensure all accidents and incidents were reported when they occurred. One person's care notes had never been audited, so the provider could not be assured staff knew how to report and appropriately respond to an accident or incident.
● The provider had not done all they could to identify and address potential safety risks in people's homes. There was no evidence people had been consulted or their mental capacity assessed to evaluate potential risks and so take action to keep people safe. In March 2020, the provider had identified there was a risk people may trip when walking around their home. The risk remained in December 2020 and the provider had not taken any action to reduce the risk. We observed an additional risk that people may fall when entering and leaving their home, as the handrail at the top of a steep flight of steps to people's front door was disintegrating due to weathering. The provider had not identified this potential risk, nor taken any action, such as contacting the landlord to address the safety concern.
● The provider did not have full oversight of concerns with people's safety. Systems were not in place to learn lessons or reduce the chance of the same things from happening again.

There were ineffective systems to identify and monitor significant events with regards to people's health and safety. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Effective systems were not in place to ensure there were sufficient numbers of trained staff to keep people safe. Required recruitment checks on staff were not always undertaken. There was no evidence that two staff members, one of whom was providing care, had completed any recruitment checks.

● During the inspection visit, it was not possible to establish which named staff members were providing personal care to people. The provider gave us a list of the names of staff supporting people, but this did not correspond with staff files or the list of staff who had been spot checked supporting people. A member of staff, who the provider told us carried out spot checks, did not have a staff file. When we visited a person's home, we met a member of staff who was not on the provider's staff list nor did they have a staff file. When we rang a member of staff on the provider's list, they told us they had not supported people for a year. Therefore, it could not be assured all staff had been checked as suitable or had the necessary training to keep people safe.

● Training records confirmed all staff had received training in how to recognise the signs and symptoms of abuse and in infection control. However, the provider did not have an accurate list of staff who supported people. Therefore, it could not be assured all staff that supported people had the knowledge and skills to protect people from harm and to minimise the spread of any infection.

The provider had no oversight of staff deployment to ensure staffing was kept at safe levels as they did not have access to the staffing rota. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service checks (DBS) had not been obtained in a timely manner. Two staff members who had started their induction did not receive their DBS checks until several months after they had begun working. These staff had been working unsupervised without these checks, which help employers make safe recruitment decisions. There was no record or written note to indicate either staff member's referees had been telephoned to check they had written these staff members' references. It is important to check that references received electronically are not fraudulent.

● The staff rota was not available at the office. The provider told us it was available at people's homes. We visited two people's homes, but staff were not able to give us a copy of the staff rota. Staff told us the staff rota was shared by a senior member of staff on a social media site and that staff were able to swap shifts between them. The provider did not have access to this information and therefore had no knowledge of which named staff were supporting people at which times or if there were any staffing shortfalls.

The provider had failed to ensure they had effective recruitment procedures. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● There were inadequate systems to ensure everyone's safety.□

● We contacted the agency office and the provider on 25th and 26th January to notify them of our inspection visit. We did not get a response. Therefore, we sent a safeguarding referral to the local authority as we were concerned about people's safety. The provider did not contact us until the afternoon of 29th January.

● A relative said they trusted staff and felt their family member was safe.

Preventing and controlling infection

● There were inconsistencies in systems to ensure the prevention and control of infection.
● Staff whose names were on the staff training rota had completed training in infection control. In addition, we identified staff who were not on the rota and had no file, so we could not be assured they had completed training. The provider told us staff had completed additional training in the use of personal protective equipment due to the covid outbreak. This was confirmed by some, but not all staff.
● We saw that personal protective equipment, such as gloves, aprons, face masks and hand gel were available in people's homes.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to ensure people consistently received personalised care that met their needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9.

● Improvements in care plans were not consistent across the service. There had been improvements in three people's care plans as they contained important information about their personal histories. This helped staff to know people better so they could provide personalised care. However, one person's care plan did not contain information about their personal history or likes and dislikes.
● Care reviews were irregular and not person-centred. We did not find any evidence that people's care reviews had involved the person being supported. Records of review were not always accurate. The date of one person's care review was the day we inspected, when the review could not have taken place. Another person's care was reviewed in December, but there was no record in the person's daily notes that this review had taken place or that they had been present and involved.
● Some people were supported by live-in staff who cared for them a set number of weeks at a time. Guidance from the National Institute of Clinical Excellent (2015) sets out the principles of delivering home care. One of these principles is to, "Ensure there is a transparent process for 'matching' care workers to people, taking into account: the person's care and support needs, and the care workers' skills, and if possible and appropriate, both parties' interests and preferences." There was no process to 'match' people and staff which enhances their experience to be supported by staff whose personality matches their own and to take part in shared interests.
● The provider's statement of purpose set out that people would have regular key worker sessions where progress towards personal goals would be monitored. We found no evidence key worker sessions or reviews took place.

People did not consistently receive personalised care that met their needs. This was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At the last inspection end of life care was identified as an area for further improvement. This was because the provider told us they had consulted people about their end of life wishes and choices, but they had not been recorded.
● At this inspection there was some information about people's wishes at the end of their lives. This included who the person wanted to be involved in their care at the end of their lives.
● There were policies and procedures to guide staff how to care for people at the end of their lives. This included working with healthcare professionals, so people experienced a comfortable, dignified and pain-free death.

Improving care quality in response to complaints or concerns
● Everyone who used the service had communication difficulties and an easy read version of the complaint's procedure was available. The provider stated in their action plan that talk time/keyworker sessions with each individual would be recorded. These sessions are an opportunity for staff to check with people if they had any worries or concerns. The provider was not able to provide any evidence these sessions were taking place.
● The provider told us there had been no concerns or complaints since the last inspection.
● A relative told us staff and the provider listened to any issues that were raised. This relative told us, "I give him (the provider) a text or e-mail and he doesn't hesitate in getting back nine times out of 10. I phone occasionally and my calls get answered."
● Staff knew how to respond to any concerns raised.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● It had been assessed that some people may benefit from information being communicated in pictures and symbols.
● A range of documents had been written in easy read, using simple words and/or pictures to help people understand their content. This included the service user guide, complaints procedure and people's care plans.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Information about how people liked to spend their time was recorded in their care plans. People were not able to take part in their usual activities such as attending a day centre and trips out in the car due to the Covid-19 pandemic. Daily notes indicated that people listened to music and watched television. A relative told us, "Staff stimulate X as best they can. They laugh and joke with him."
● Staff supported people to stay in contact with people who were important to them, such as relatives. A relative said contact was by telephone due to the pandemic, but that when they visited staff always welcomed them. They said they were kept up to date with changes in their relatives' care needs.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to have a registered manager in post for the carrying on of the regulated activity of personal care. At this inspection there was still not a manager in post who was registered with CQC.

At our last inspection the service was registered to operate from an address in West Malling but was operating from an unregistered address in Chatham. At this inspection the service continued to operate from an unregistered location.

At our last inspection the provider had failed to display the latest CQC inspection rating at the service and on their website. This is so that people, visitors and those seeking information about the service can be informed of our judgements. At this inspection the provider had neither displayed their rating of Requires Improvement at the office location nor on their website.

- There continued to be lack of clarity of roles, responsibilities and management accountability. The provider had not notified us of who was managing the service in the absence of a registered manager and the long-term absence of the Nominated Individual.
- At the inspection the provider told us the service was being managed by himself with tasks delegated to a senior carer, his personal assistant and an administrator. The provider then said the personal assistant may not have the skills and knowledge to review care records and spot check other care staff. The provider went on to say the administrator was not an administrator but was management qualified and worked in children's services in another part of the agency which did not provide the regulated activity of personal care. We were unable to confirm this information as this person's staff file was not available at the office. We did not see this staff member's name in any spot checks or review of care plans and associated risk assessments.
- The senior carer said although they sought support and advice from the provider and the administrator/management qualified member of staff, they mainly contacted another senior member of staff. The provider did not mention this other senior carer as being involved in the management of the service. However, they had undertaken reviews of care records and spot checks of other staff.

Continuous learning and improving care; Engaging and involving people using the service, the public and

staff, fully considering their equality characteristics
At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity. Records relating to people's care and support were not always accurate or accessible. The provider had failed to seek and act on the feedback of people and their representatives for the purpose of continually evaluating and improving the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17.

● The provider had not implemented principles of good quality assurance nor driven improvement. The service continued not to be well-led as the provider did not have full oversight of the service. Quality monitoring systems were not sufficient or robust enough to identify shortfalls and drive continuous improvement in the service.
● The provider had failed to make the necessary improvements to shortfalls in risk management, medicines and person-centred care which had been identified at the last inspection. They had also failed to identify shortfalls in staffing levels and staff recruitment, identified at this inspection.
● The service had a number of characteristics of a closed culture. A closed culture is a poor culture in a health or care service that increases the risk of harm. Characterises include people's care plans not showing their choices and decisions, lack of staff support from managers and the provider not responding to requests for information. This had an impact on one person's care whom the provider told us did not react well to new people. This person was supported by the same two staff members, one of whom who was responsible for oversight of their care. The provider had not considered introducing new staff in case staff were ill or left the agency.
● It was not possible for the provider to ensure all staff supporting people had the necessary qualifications and skills to support people as there were discrepancies in which named staff supported people. The staff rota was not reviewed to ensure people's needs were met. Spot checks were not carried out on all staff supporting people. Spot checks are important when staff work alone, to directly observe their practice and make sure they were providing care to a satisfactory standard.
● Records were not easily accessible as they were stored in people's homes rather than the office location. It was therefore not possible to get an overview of someone's care without visiting their home. Senior staff reviewed people's care records, that they were also responsible for writing. The provider said these records were brought to the office so they could check them. There was no evidence this occurred. A number of records used by the provider to monitor people's care and treatment had not been completed. These included monthly reports, activity plans and keyworker reports.
● The provider had used surveys to gain feedback about the care provided and received five responses. Everyone who responded stated that excellent or very good care was provided and that they would recommend the service. However, all survey questionnaires were dated 1st January 2020 and none of them had a name or signature. The surveys were directed towards people who used the service as questions included, "How well do our care workers do in being willing to change their ways of working to suit you?" and "How do our care workers do in not hurting you when attending to you?" However, none of the four people who used the service had the ability to understand the questions being asked.
● Staff had not been sent surveys to gain their views about how the service could improve. Therefore, it was unclear whose views had been captured.

There were ineffective systems to assess, monitor and improve the quality and safety of the service. Records

relating to people's care and support were not accessible. The provider had failed to seek and act on the feedback of people and their representatives for the purpose of continually evaluating and improving the service. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff said they attended staff meetings and supervisions and records were kept of some of these meetings.

● A relative said they were very satisfied with the level of care their family member received and would recommend the service to others.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider continued to not adhere to their duty of candour policy, which outlined the importance of being open and honest and how they should respond when something went wrong.
● The provider had not been open and honest in their communication with Care Quality Commission. The provider only responded to our contact by telephone and e-mail, four days after we first contacted them. The provider told us the telephone number we had for them was not a direct line and gave us another telephone number. When we telephoned the office number, staff at the office confirmed they e-mailed the provider at the same e-mail address that we had contacted them. The provider told us sometimes their e-mail account did not work and at other times they received over 1,000 e-mails a day and so could not reply to them all.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not have oversight of the culture of the service to ensure it met its visions and values.
● Aspects of one person's care had characteristics of a closed culture. The person was not able to speak up for themselves due to lack of verbal communication skills. There was no monitoring of staff supporting the person and no evidence of positive engagement between staff, the person and their representatives.
● Staff said they communicated well with other team members and that other team members were the first person they rang for advice and support. When they could not resolve an issue, they told us they contacted the provider who usually responded to in a timely manner.

Working in partnership with others
● The service continued to work in partnership with a health professionals such as doctors and supported people to attend health care appointments when needed.
● Feedback from the local authority was that they continued to have concerns about people's safety.