Saint John of God Hospitaller Services

St John of God Care Services Supported Living

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 13 and 19 September 2018 and was announced. The provider was given 48 hours' notice of our inspection, because this is a small service and we needed to be sure that someone would be in.

St John of God Care Services Supported Living provides care and support to people living in 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 supports people living within Richmond, Catterick Village and Leyburn and specialises in supporting people with a learning disability or autistic spectrum disorder. At the time of our inspection 25 people received support.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

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

Whilst staff had completed some training essential to their role, training specific to the needs of the people who used the service had not been provided. This included epilepsy and positive behaviour support training. We have made a recommendation about the provider ensuring staff received the specialist training required. For one person who was responsible for assessing the competency of the staff with their medicines support, they themselves had not had their competency assessed since 2015. Whilst mental capacity assessments were completed around medicines support, people's mental capacity in other areas of their lives had not been assessed, when the person was thought to lack capacity. Best interest decisions had not been recorded to demonstrate professionals and relatives had been included in discussions about the person's care and the actions taken were in the person's best interest and the least restrictive option. Staff received supervisions, however appraisals had not been completed.

The quality assurance checks completed had not identified some of the issues we highlighted during our inspection, including staff having not completed all necessary training, appraisals having not been completed and mental capacity assessments not in place. The registered manager and provider were responsive to the issues raised and were in the process of developing their quality assurance tools to ensure the safety of the people who used the service. The management team promoted a person-centred culture

and demonstrated they wanted the service to continually improve.

People told us they felt safe. Staff understood the actions to take in the event of an accident or incident or if they had any safeguarding concerns for people. Risk assessments were in place when there was an identified risk, however we found for one person their risk assessment had not been updated following a fall. This was completed between day one and two of our inspection. There were sufficient staff in place to meet people's needs and to simply spend time with another engaging in activities. People received their medicines as required. For one person, protocols for their as and when needed medicines were not all in place. Staff undertook their medicines training and had their competency assessed.

Although consent forms were not in place, staff did seek people's consent and understood the importance of this. People were supported to eat a diet of their choosing and people's weight was monitored if there were concerns about this. The staff and management team supported people to attend healthcare appointments and had formed closed links with healthcare professionals whose input was requested when there were concerns about an individual. People who used the service chose the furnishings and decoration for their bedrooms and had input into decisions about updates made to the decoration of communal areas.

People who used the service and their relatives told us staff were caring and promoted their privacy and dignity. Staff spoke about people with compassion and in a respectful manner. People were supported to maintain important relationships and visitors to the service told us they always felt welcome. Information was available about advocacy organisations to ensure people had the support they needed to speak up about matters that were important to them.

Staff were familiar with people's needs and provided person-centred and responsive care. Care plans were detailed and provided information about people's background, needs and strengths. We found one care plan had not been updated with important information which the registered manager agreed to update. People engaged in a variety of activities, according to their personal tastes, and engaged in volunteering and opportunities for further learning. The provider had a compliments and complaints policy in place and this was available in different formats dependent on people's requirements. People told us they felt confident to raise any issues or concerns with the staff and management team.

People who used the service and their relatives were positive about the management team and expressed confidence in them. Tenants meetings were arranged for people who used the service and staff meetings were held to share important information. The registered manager and provider were a visible presence within the houses and were keen to provide people with person-centred care.

At the last comprehensive inspection in January 2016 the service was rated good in each domain. At this inspection we found the service had not maintained this standard and rated it requires improvement. This is the first time the service has been rated requires improvement.

Further information is in the detailed findings below.

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.

Risk assessments were completed for areas of identified risk and staff understood the control measures in place.

People received their medicines as prescribed.

Safe recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received specialist training to meet the needs of the people who used the service.

Whilst staff had received supervisions, annual appraisals had not been completed.

Staff sought people's consent before providing care.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us staff were kind and caring.

Staff promoted people's dignity and privacy through the support they provided.

Information about advocacy services was available.

Is the service responsive?

Good

The service was responsive.

People received person-centred care from a staff team who were

familiar with their needs.

Detailed care plans were in place which provided information about people's likes, dislikes and abilities.

People were supported to engage in a variety of activities, tailored to their personal tastes.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems and checks in place had not highlighted some of the issues we found during this inspection.

The registered manager and provider were in the process of embedding new systems of quality assurance.

Staff told us they were well supported by the management team.

St John of God Care Services Supported Living

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 13 and 19 September 2018. This inspection was announced and we gave the provider 48 hours' notice of the inspection visit because it was a small service and we needed to be sure people using the service would be in. The inspection was undertaken by an adult social care inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who supported this inspection was a specialist in learning disabilities and autism spectrum disorder and assisted by speaking with people who used the service.

We undertook a visit to some of the supported living locations. We were given a tour of the facilities which provided an opportunity to observe staff interactions with one another and with the people supported by the service. We visited the office location to meet the registered manager and review care records and policies and procedures.

We used information the provider sent us in the Provider Information Return. This is information providers are required to send us at least once annually to give some key information about the service, what the service does well and any improvements they plan to make. This contributed to our understanding of the service.

Before our inspection, we reviewed information we held about the service, which included information shared with the CQC and notifications sent to us since our last inspection. The provider is legally required to send notifications about events, incidents or changes that occur and which affect their service or the people

who use it. We also contacted the local authority commissioning group and the local Healthwatch, a consumer group who aim to share the views and experiences of people using health and social care services in England. We used this information in planning our inspection.

During the inspection, we spoke with five people supported by the service and two relatives. We spoke with two members of staff and both registered managers. We spoke with nine members of staff including the quality and safety manager, registered manager, deputy manager, two senior support workers and four support workers.

We reviewed documentation relating to four people including risk assessments, care plans and reviews. We looked at three staff files and an overview of staff training, supervisions and appraisals.

We considered information relating to the running of the service including staff rotas, compliments and complaints and a series of policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. During our visit people appeared comfortable within their home environment and at ease in the presence of staff. People's relatives expressed confidence that safe care was provided to their loved ones, with one relative stating, "The best thing is knowing [person's name] is safe and happy. We have got the best place possible for them."

People told us they received their medicines as needed and the medicine administration records confirmed this. It is considered best practice to have protocols in place for as and when needed medicines to clearly document when the person may require this. Whilst the majority of protocols were in place there was one person for whom these were missing. This meant staff did not have the necessary information to guide them and to ensure this person received their medicines in a safe and consistent way. We spoke with both the deputy manager and registered manager about this who agreed to ensure these were completed. Staff undertook medicines training and their competency to administer medicines was assessed. We found, however, for one person responsible for assessing people's competency that their own competency had not been assessed since 2015. We have discussed this further within the effective domain.

Detailed risk assessments were in place for areas of identified risks including the use of sharp objects, moving and handling and going outdoors. There had been one occasion where somebody's risk assessment had not been updated following a fall. This was highlighted to the registered manager and was implemented between day one and two of the inspection. Risk assessments provided clear instruction about the control measures in place to reduce potential risks and staff were aware of these. Staff and the management team were mindful not to overly restrict people in their day to day life. A person's risk assessment stated, 'It is important for [the person] to have choice and freedom, access to the community and to lead a fulfilled life.' If a person expressed a wish to engage in an activity that may have a level of risk attached to it this was not dismissed. Staff instead considered ways to reduce the risk and ensure the staff supporting with this activity had the right skills to respond.

Positive behaviour support is a person-centred approach to supporting people who may become anxious or display behaviours that may challenge. Risk assessments were in place and detailed what actions staff needed to take to support somebody if they were distressed. Staff demonstrated a clear understanding about how to approach people and the actions they needed to take to ensure people were safe and received the support needed.

On the day of our inspection there was sufficient staff to support people. Staffing levels meant staff had time to support people with activities of their choosing or to simply spend time with them, in addition to ensuring their basic needs were met. The staff rotas we saw showed staffing levels were consistent and effort was made for people to have the same staff supporting them. Staff were positive about the staffing levels, with a member of staff telling us, "Staffing here is great and we can be more relaxed with people and have a chance to sit down with them."

There were no agency staff working on the day we visited people's homes but they were used to ensure

staffing levels were safe. The registered manager advised us they tried to ensure the same agency staff were used so the people who used the service had consistency. The service received agency profiles which contained a picture of the worker, details of training and the checks completed to ensure they were safe to work with people. The service did not have a recorded induction with the agency staff. This was discussed with the registered manager who agreed to ensure these were in place.

New staff were recruited safely. Potential candidates completed an application form, had an interview, provided references and underwent a Disclosure and Barring Service (DBS) check. DBS checks return information from the police national database and help employers make safer recruitment decisions and minimise the risk of unsuitable people working within a care setting. Part of the recruitment process was for potential candidates to visit people who lived in the service. Their interactions with people were observed and feedback was sought from people who used the service. This enabled people who used the service to be involved in the recruitment process and to say whether they would be happy to be supported by a potential candidate.

The provider had safeguarding and whistleblowing policies in place. These policies were overdue their review, which the provider was aware of and in the process of addressing, however they were in line with current legislation. Staff understood potential signs of abuse and were confident about how and who they would report their concerns to. A member of staff told us, "If I thought anybody was being put at harm, I would report it immediately."

Staff understood the actions to take in the event of an accident or incident and took the necessary follow-up actions, such as referrals to other professionals or agencies. The provider completed internal investigations following serious events, such as a person having a fall, in accordance with the provider's policy. This was, therefore, an opportunity for the provider to check the necessary actions had been taken in response to the incident and that documentation was in place. The registered manager also completed a monthly analysis of events within the service which was also sent to senior managers for them to review and respond to.

The service was clean and free from odour and people who used the service were encouraged to help maintain their home environment. People's relatives noted the cleanliness of the service with one person stating, "It is immaculately clean, [the person] is very particular about the home and cleanliness." Personal protective equipment (PPE) was available throughout the service to ensure staff minimised and controlled the spread of infection. Staff had completed the infection control training.

Fire drills and tests of the fire alarms were completed. People had personal emergency evacuation plans to ensure staff were aware of the support they required if there was an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff undertook a variety of training including moving and handling, first aid and safeguarding. However, training specific to the needs of the people who used the service had not been provided. For example, risk assessments for people who had epilepsy identified that staff required training. However, epilepsy training had not been completed. Training in relation to positive behaviour support and autistic spectrum disorder were either out of date or had not been completed. This was highlighted to the registered manager and provider who immediately arranged an epilepsy training session and staff were registered for online training as an interim measure. The provider informed us they were in the process of upskilling a member of staff to deliver positive behaviour support training to the rest of the team. As people were supported by an experienced staff team who were familiar with their needs, and could share their knowledge with new staff, this reduced the potential risk of staff not understanding what actions to take.

We recommend the provider ensures staff have received specialist training based on the needs of people living with a learning disability or autistic spectrum disorder.

Staff member's competency was regularly assessed in areas such as medicines and moving and handling. However, for one person who assessed other people's medicines competency they themselves had not been assessed since 2015. This was not in line with the provider's medicines policy which stated, 'Staff must be observed administering medication by a competent assessor'. This was discussed with the provider and registered manager who acknowledged our concerns and agreed to ensure their competency was assessed as a priority.

Supervision is a process by which an organisation provides guidance and support to their staff. Supervision records showed supervision was an opportunity to discuss people's training and development needs, any concerns they had and to consider their understanding of key topics such as safeguarding. Staff confirmed they received regular supervision as part of their role and felt well supported. However, annual appraisals of people's performance were not up to date. For two of the staff files we reviewed, appraisals had not been completed since 2015 and no appraisal dates were scheduled for any of the staff. Following our inspection, we received a schedule of when appraisals would be completed.

New staff completed an induction before supporting people. This consisted of shadowing other staff, reading people's care plans to understand their needs, likes and dislikes and commencing their training. A staff member told us, "I watched what other staff were doing with the hoist, bathing and feeding and just spending time with people." Probationary reviews were completed to discuss the person's understanding of their job role and performance. This demonstrated new staff were provided with the necessary support to care for people.

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

possible.

When there were concerns about somebody's understanding of their medicines, capacity assessments were completed. However, no other capacity assessments were in place. This included for people who were considered to lack capacity in relation to their day to day needs. Best interest decision records had not been completed to show professionals and other important people in the person's life agreed with the proposed support. However, people's relatives told us they were included in discussions about their loved one's care. We, therefore, concluded this was a recording issue and the registered manager and provider agreed to implement these.

People can only be deprived of their liberty so that they can received care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedure within the community is called a Deprivation of Liberty (DOL). Some of the people who used the service were subject to a DOL, however the staff and management team understood the conditions of these and were mindful to reduce restrictions for people.

Signed consent forms were not in place to demonstrate people agreed to their support and the sharing of important information. People did, however, tell us staff sought their consent before providing care with one person stating, "Staff always ask before they do things." A staff member told us, "I always give people the opportunity to say no." During the inspection we observed staff seeking people's consent and being guided by the person. This demonstrated staff were aware of the importance of people being in control of their day to day support.

People received support with their nutrition and hydration needs, when required. A person who used the service told us, "I can have a snack or a drink anytime and I make a packed lunch by myself without prompting." People who used the service and staff discussed the food people wanted to eat for the week and created a varied menu of meals. If people didn't want to eat this meal other options were available. People who used the service and staff had a roast dinner each Sunday and takeaways on Saturday night, which they told us they enjoyed.

People were weighed if there were concerns about their dietary intake. People's care plans stated people needed to be weighed 'regularly' and lacked detail about how often. However, the weights reviewed showed people's weight was consistent. We discussed this recording detail with the provider and the registered manager who agreed to update this.

Daily records were completed for staff to document support provided to somebody and any important information to handover. These notes were respectful and person-centred.

People had access to healthcare professionals and were supported to attend appointments. There was regular input from the mental health team, speech and language therapists and GP's and this guided the way they supported people. When staff noted a deterioration in people's needs, such as with their walking or mental health needs, this was highlighted to the necessary professionals.

Health action plans were in place along with detailed hospital passports which contained important information about the person should their care transfer to a different service such as a hospital.

People's bedrooms were comfortable and personalised to their own tastes; one person had decorated their room with pictures and memorabilia from their favourite football club. People who used the service were involved in discussions about the decoration of communal areas when these were updated. A person told

us, "We have had a new kitchen and we all chose the colours and worktops for it."

The staff utilised sensors in their support of people, such as epilepsy sensors. This meant staff were alerted if the person required support but reduced the level of monitoring and observation.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us staff were caring. Comments included, "Staff are very caring", "The staff are very obliging" and "I tell the team how wonderful they are."

We observed caring and warm interactions between staff and the people they supported. For example, a person had become distressed and the staff member offered reassurance and comforted them. For another person, they had attended an activity in the community but wanted to come home as they weren't feeling well or enjoying themselves. Staff immediately collected the person and ensured they were made to feel comfortable once they returned home.

People who used the service and their relatives told us staff promoted their privacy and dignity through the way they supported them. People said, "Staff don't just walk into my room" and "They are very good at respecting people's dignity." A staff member told us, "I always knock on their door and close the door, blinds and window if I'm giving personal care support to give them privacy." People's care plans reminded staff about the importance of promoting people's dignity during personal care. For example, 'Staff to ensure [the person] is aware of being hoisted, is comfortable and their dignity is upheld at all times.'

People's relatives told us they were made to feel welcome when they visited. Comments included, "It is a lovely place to go and we are always made to feel welcome" and "I'm made to feel very welcome, I go regularly and I am like part of the family." People's relatives told us how they felt reassured following these visits that their loved ones were receiving good care. Staff also supported people to maintain important relationships by assisting them to visit their families and buy gifts, such as flowers, beforehand.

Staff were positive and passionate about their job and spoke about the people they supported with respect and compassion. Comments included, "I love my job. I go home on a night and feel like I've done some good", "People are looked after fantastically. I'd be happy to have a relative looked after here" and "I love working here. I really like the tenants and the staff and we all get on well."

Staff encouraged people to use and build upon their independent skills. During our visit we saw people were engaged in the practical tasks of daily living, such as assisting staff to prepare meals, doing the washing up and setting the table for dinner. A person who used the service told us, "I do my own washing and do ironing with support. I have set days but sometimes I sneak down and do them on other days."

Staff actively encouraged people to make their own choices about their day to day needs. A staff member told us, "First and foremost, I ask them (people who used the service). We give choices all the time, wherever possible." Communication plans were in place to enable staff to understand people's different forms of communication and to address any barriers which may affect their ability to express their needs or wishes. One person's care plan stated, 'You may need to rephrase a question if I say, I don't know. This is normally an indication that I do not fully understand.'

There was access to information about advocacy services, which are independent organisations supporting

people to make decisions about their lives and to speak up about important matters to them. At the time of our inspection, people were receiving support from advocacy services whilst others had input and support from their family members.

Good

Is the service responsive?

Our findings

People received person-centred support from a staff team who were familiar with and responded to their changing needs.

Person-centred and ability focused care plans were in place which described people's physical, emotional and mental health needs and the support required. They also contained information about people's background, their family circumstances and outcomes or goals they wanted to achieve. Goals may include further education, employment or to explore social interests. Care plans were generally updated when the person's needs changed, however for one person who had recently been assessed as requiring a soft textured diet, this information was not in their care plan. We advised the registered manager about this, who agreed to ensure this was updated. This information was contained within the person's health action plan and staff were aware of the diet they required. This reduced the risk of the person receiving a diet which was not suitable for their needs.

Reviews of people's support were completed but their goals and wishes for their lives weren't revisited as part of this process. Reviewing these would help to establish whether additional support was needed for the person to meet their goals or to set new goals if they had already achieved what they wanted to. People who used the service told us they were doing the things they wanted to such as going on holiday and volunteering. We, therefore, concluded that this was a recording issue which required further development.

People were supported to engage in a wide variety of activities of their choosing and had opportunity for stimulation and learning. On the day we visited, most people were not at home as they were attending computer clubs, had gone shopping or had popped out to a local café with staff. People's records showed they had been supported to engage in a variety of activities. This included going to the cinema, meals out, such as fish and chips, and watching a pantomime. A person's daily records stated, '[The person] went out to the hippodrome to watch the Elvis Story, they thoroughly enjoyed themselves clapping and dancing with a smile on their face.' A relative told us how staff had encouraged their loved one to go out more into the community and the positive impact that has had on them. Some of the people who used the service had gone on holiday together with the support of staff and spoke with excitement about plans for their next holiday. Others preferred not to go out as much and stayed at home. For these people, staff spent time talking with them and we saw them looking through catalogues together and making preparations for their Christmas dinner.

People who used the service volunteered in their communities which provided an opportunity to develop skills and spend time doing something they really enjoyed. For one person they volunteered with a local horticulture organisation whilst another person worked at a railway station. Both people spoke about their jobs with great enthusiasm.

People's relatives told us they were informed of any changes or important information. A relative told us, "You can ring up with any queries and it is sorted. [Staff member] is a wonderful team leader, everything is organised and we are in touch nearly daily."

Through our discussions with the registered manager and the provider, it was evident they understood issues relating to equality and diversity. People's rights were upheld and they had been supported to explore and have relationships and to attend places of worship. When staff had been unable to assist a person to a church service, other support networks were considered to ensure the person attended. Staff completed equality and diversity training to develop their awareness and understanding in this area.

The provider had a compliments and complaints policy in place, which was also available in an accessible format within people's houses. A member of staff told us, "If there is any concern whatsoever, there is a complaints procedure near the telephone. If they have anything they want to say we'll help them fill this in." People who used the service and their relatives told us they would feel confident to raise any concerns and that these would be addressed.

At the time of our inspection, the staff were not providing people with end of life support but understood the need to record people's wishes in relation to this.

Requires Improvement

Is the service well-led?

Our findings

The registered manager registered with the CQC in September 2018. Prior to this they worked for the service as a senior support worker, predominantly based within one of the houses. They were, therefore, familiar with the structure and processes of the organisation. The registered manager visited other houses on a regular basis to become more familiar with the people who lived there and the staff who supported them. The registered manager was supported by an experienced deputy manager and told us how supportive the provider had been during the transitioning period into their new role.

We looked at the procedures in place for quality assurance and governance. These enable registered managers and providers to monitor the quality and safety of the service and to drive improvement.

Although checks were being undertaken these had not highlighted some of the issues we found during this inspection. This included specialist training having not been completed, to enable staff to competently deliver support, mental capacity assessments, best interest records and consent forms not being in place and appraisals having not been completed. We did not find these issues had impacted on the people who used the service as they were supported by a consistent staff team, who in turn received support, and they were familiar with their needs. However, these were important factors which needed to be addressed to ensure people received consistently effective care.

Throughout the inspection the registered manager and provider were open and responsive to the issues we raised and took immediate actions to address these. Staff training was arranged, appraisals were scheduled and the documentation highlighted, between day one and two of the inspection, was updated.

A series of audits were undertaken by staff who worked within each house, in addition to the registered manager and provider audits. Senior support workers completed checks of people's medicines and care plan's and the maintenance of the property. This information was then reviewed by the registered manager. The quality of these checks was variable and some contained limited information about what had been reviewed and the actions taken. This had been recognised by the registered manager who had recently introduced visits by the deputy manager to review the checks completed. This provided a further opportunity for the deputy manager to talk with people who used the service, to ensure they were happy with the support they received, and to observe staff member's interactions with people.

The provider understood the importance of an effective quality assurance framework and were in the process of developing this. A new audit had been devised, and was being embedded, to assess in line with CQC's assessment framework, but this had yet to be undertaken at this service. The provider had undertaken visits to the houses to assess their fire safety, documentation and considered staff member's interactions and general atmosphere. The provider's quality improvement team had been expanded to provide more support to registered managers and the service's they were responsible for.

We noted one safeguarding incident where CQC had not been notified. The necessary actions had, however, been taken in response to the incident including liaison with the local authority. The registered manager

acknowledged this oversight and submitted a retrospective notification. The provider discussed statutory notifications with their other registered managers to ensure they understood the requirement to send these. Other notifications had been submitted appropriately and the registered manager was clear as to their responsibility.

The registered managers from each of the provider's services met monthly to discuss any difficulties or lessons learnt within their services. This provided an opportunity for the registered managers to support one another and promoted shared learning. A member of the management team told us, "What we learn in one service we roll out to another." This demonstrated to us that the provider wanted their service's to continually grow and improve.

The management team were a visible presence within the service and promoted a culture of open discussion with staff and were passionate about people receiving person-centred care.

People who used the service and their relatives were positive about the leadership of the service. Comments included, "Everything seems to be above board, its great and there are no anxieties from my perspective" and "It is absolutely brilliant. I can't find the words to tell you how good it is."

Tenants meetings were arranged on a regular basis if people wanted to participate in these. This was an opportunity to talk about the menus, activities people wanted to do together, such as arranging a barbeque, and any issues to address.

Staff told us they felt well supported and respected within their role and said, "Nothing is ever too much trouble for them [the registered manager]" and "This will be my forever job. It's a lovely company, lovely staff and loads of support from seniors and management. I can speak to them about work or personal things and they would keep confidentiality."

Staff team meetings were also held involving staff from each house to update one another and share important information from the organisation about the people they supported.

On-call arrangements were in place to ensure, in an emergency, there were people to respond and provide additional support if required. This was made up of senior members of the staffing and provider team.

The registered manager maintained close links with other organisations in the community, including health professionals and the local authority, and shared information as required.