Voyage 1 Limited

The Maltings

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The Malting's provides care and accommodation to three people with learning disabilities and this inspection was unannounced and took place on 26 July 2017.There were three people living at the service.

At the previous inspection dated July 2016 we found breaches of Regulation 11 and 17 and at this inspection we found there had been improvements with quality assurance systems. We also found members of staff were knowledgeable about the principles of the Mental Capacity Act and consent to care had been mainly sought in line with legislation and guidance.

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

The staff were knowledgeable about the principles of the MCA and had attended the training. Mental capacity assessments were in place for some specific decisions which included dental treatment and personal care. However, personal care assessments did not cover staff making decisions for administration of medicines and topical creams.

Care plans and combined risk assessments were in place. However care plans were not always updated for some people as their needs changed. The care plans describing the support for one person were not consistent with other documentation about the person's ability to move around the home independently.

Risk assessments and care plans were combined. The staff were aware of the risks to each person and how they were managed. Staff said there were risk assessments in place on how risks were to be minimised.

Medicine systems needed some improvements. There had been persistent errors, however the registered manager had taken appropriate action to ensure safe handling of medicines. Where people took their medicines other than in accordance with the prescription, for example they chewed the tablets or had them in food rather than swallowing, the pharmacist had not been contacted to ensure that this was appropriate..

Medicine Administration Records (MAR) charts were signed by staff to show the medicines had been administered. Body maps were in place for the applications of topical creams.

Daily routines included people's preferences as well as the assistance staff had to provide. Where people were able; guidance was given to staff on supporting the person to manage some of their personal care needs for themselves.

People were not able to tell us what feeling safe meant to them. We saw people approach staff for company and when they needed assistance or support. We heard people singing with staff and depending on the

situation we saw staff treat people with kindness and firmness when it was needed. The staff we spoke with were knowledgeable about the procedures for safeguarding adults from abuse. We saw copies of the No Secrets guidance pinned onto notice boards in the office and kitchen. This meant the procedure was available to staff and visitors to the home.

The staffing levels had improved within the last 12 months and there was a stable team. New staff were recruited to vacant posts. The rotas in place showed there were two staff on duty at all times of the day and night. At night the staff slept in the premises. Staff told us the staffing levels were appropriate to meet people's needs and to undertake activities with them.

Staff were supported to meet the responsibility of their role. New staff had an induction to prepare them for their job. Staff attended training set by the provider as mandatory and other training specific to the needs of people living at the service. Staff had an opportunity to discuss issues of concerns, performance and training needs during one to one supervision with their line manager.

People were subject to continuous supervisions and DoLS applications were made. However authorisations had not been received. While DoLS applications were made we noted they did not cover monitoring systems for people at with epilepsy. The registered manager understood when they needed to make applications and that the applications had been made appropriately.

Health action plans and Hospital passports were in place. We saw people had access to GP and other healthcare professionals. Staff said the GP trusted their judgements and acted upon their observations. People had regular check-ups with opticians and dentists. Speech and Language Therapist (SLT) assessments were in place for one person at risk of choking.

Staff told us about the importance of developing relationships with people and were clear that people were their priority. Staff gave us examples on how they respected people's rights. We saw two people move around the home without staff support and one person relied on the staff to support them around the home.

The views of people were gathered. Quality Assurance systems were in place. The registered manager consolidated all actions from audits and visits into an action plan. Target dates and people responsible to meeting the action were identified within the plan.

We have made a recommendation about care planning.

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.

Medicines were generally managed safely. However the pharmacist was not consulted to determine that the integrity of the medicines was not compromised by the medicine being taken with food and by chewing the medicines.

We saw people seek the attention of the staff for company and for support and assistance. Staff knew the types of abuse and the responsibilities placed on them to report abuse.

Risk assessments were combined with the care plans. Members of staff knew the risk to each individual and the actions needed to minimise the risk.

There were sufficient staff to support people and we observed that staff were visible and available to people.

Is the service effective?

Good

The service was effective

Care plans contained mental capacity assessments and where people lacked capacity best interest decisions had been made.

Staff enabled people to make some day to day choices and explained how people made staff aware of their decisions.

Staff had the knowledge and skills to carry out their roles and systems were in place to support staff with the responsibilities of their role.

People had access to ongoing healthcare

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion. When people showed signs of distress we saw staff distract the person with an activity.

Personal details and profiles gave guidance to staff on people's relationships with family and friends, their likes and dislikes and preferences on how personal care was to be met.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans although person centred and reviewed annually they were not monitored in between reviews to assess their effectiveness. Care plans were not always updated when people's needs changed.

The people living at the service were not able to tell us about the care they receive and the approach used by the staff to deliver personalised care.

There were no complaints received at the service since our last inspection

Is the service well-led?

Good

The service was well led.

The views of people were gathered at house meetings and by surveys. The feedback was generally good and the registered manager told us this feedback was discussed at team and tenant meetings.

Quality assurance systems were in place. Action plan were in place on meeting shortfalls identified at the audits.

Staff said the team worked well together and the registered manager was approachable.

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Detailed findings

Background to this inspection

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

This inspection took place on 26 July 2017 and was unannounced.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by one inspector. 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 the registered manager and three members of staff including a bank member of staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included three care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Good

Is the service safe?

Our findings

Medicines were generally managed safely. Medicine care plans detailed how people preferred to take their medicines. For example one person chewed their medicines and another had their medicines placed on top of food. Staff told us the GP was aware of people's preferences with administration of medicines. However the pharmacist had not been consulted to determine that the integrity of the medicines was not compromised by the medicine being taken with food and by chewing the medicines. The registered manager told us the pharmacist would be consulted for advice about people preferences on taking their medicines.

Staff said mandatory training had to be attended before they were able to administer medicines. They said their competency to administer medicines was tested annually. There were photographs of people at the front of Medicine Administration Records (MAR) charts which meant that staff who were unfamiliar with people would be able to recognise them.

The MAR charts had been completed in full and there were no gaps in the charts that we looked at. This indicated that people had been administered their medicines as prescribed. When required (PRN) medicines had been prescribed. These were additional medicines that people might require at times, for example, pain relief. Pain relief protocol included the signs of pain and the maximum dose to be administered within 24 hour period. This ensured that people were being administered as required medicines appropriately

Some people had been prescribed creams or lotions. There were body maps guidance for staff to follow. While the record detailed the instruction and location for application of the topical creams the location was not illustrated on the body map. This meant staff did not have visual guidance on the applications of topical creams and ointments.

A record of medicines no longer required was maintained and the record was signed by the pharmacist to show they had received the medicines for disposal. This meant the registered manager was disposing of medicines in a safe way

People living at the service were not able to tell us what feeling safe meant to them. We saw people seek the attention of the staff for company and for support and assistance. Staff said they had attended training on how to protect people from avoidable abuse and harm. A member of staff told us the types of abuse and that they were expected to "report and record" allegations of abuse. This member of staff also said they felt confident to raise their concerns to senior managers and to the local authority safeguarding team if their concerns were not taken seriously. Another member of staff said the registered manager was made aware of concerns and it was their responsibility to "raise the alarm and if I am wrong better than the alternative. [I] expect no repercussions from these actions [taken]."

Risks were assessed and were combined with the care plans. A traffic light system was used to assess the risk level and action plans were developed to minimise the risk to an acceptable level. For example, green for go, amber for think and red for stop. For one person the epilepsy risk assessment was scored as amber

and the action plan included using sensors at night. This meant staff were alerted to the person having a seizure.

Moving and handling risk assessments included the assistance needed by people from staff to move around the home and community. We saw aids and equipment was used to support one person with their physical impairments. For example, walk in shower and using a wheelchair in the community.

Members of staff knew the risk to each individual. A member of staff said there were people with medical conditions such as epilepsy which placed them at risk of harm while others were at risk of falls and choking. This member of staff told us the actions in place to minimise risk which included rescue medicines for people with epilepsy and textured diets for people at risk of choking.

Another member of staff explained one person's vision was deteriorating and their level of support was increasing. Staff also explained the task in advance and guided the person which made them feel secure. The registered manager told us risks were constantly reviewed and from the actions taken they were at a green 'go' stage meaning that risks had been lowered and were being managed at an acceptable level.

Accidents and incidents involving people were recorded electronically and reviewed by the registered manager to ensure they had been responded to appropriately. The registered manager told us a centralised electronic system was used to document incidents and accidents. We saw there had been one incident and recorded was the nature of incident, who was involved and the actions taken were documented. They said a senior manager had access to the reports for analysing trends and patterns.

Procedures were in place to ensure that unsafe practices were identified. For example, medicine errors. Medicine errors were investigated and where persistent medicine errors were made the staff responsible were suspended from some medicines administration procedures until there was retraining. Their competency was to be checked on three separate occasions before the registered manager was satisfied the member of staff was competent with administering medicines.

A service continuity plan dated 15 May 2017 included the actions staff must take for specific occurrences such as not being able to gain access into the property and the arrangements for alternative accommodation in these events. Procedures for staff to follow during hot weather were also included and contact details of contractors for staff to report faults. Fire risk assessments were in place the potential of a fire and the measures in place to reduce this potential For example, fire alarm systems including extinguishers, the training of staff and evacuation procedures.

Personal emergency evacuation procedures were in place. These stated people at the service needed full support from staff they knew to safely evacuate the property in the event of an emergency. The rota in place confirmed the staff on duty were known to people.

There were sufficient staff to support people and we observed that staff were visible and available to people. Comments from staff were generally positive. Staff said there were two staff on duty during the day and at night two staff slept in the premises. A member of staff said the staffing levels were appropriate, there were no staff vacancies and where needed bank staff were used to cover absences. The rotas in place confirmed the comments of the staff and we saw there were two staff on duty. The registered manager told us there had been three staff vacancies and during this period agency staff were used. Recruitment had taken place and all vacant posts had been filled by new and re-employed staff.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience

and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. We saw the registered manager was informed by Human Resources (HR) when recruitment checks were completed and for the new staff to begin their induction.

Good

Is the service effective?

Our findings

At the previous inspection dated January 2016 we found a breach of Regulation 11. We found that people's capacity to make specific decisions was not always assessed. Members of staff had gained consent for best interest decisions to care and treatment from relatives without power of attorney. We received an action plan from the provider telling us how the identified breaches of legislation were to be met. At this inspection we found there had been improvements with staff knowledge of the Mental Capacity Act and overall appropriate consent was gained.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Care plans contained mental capacity assessments for specific decisions and where people lacked capacity best interest decisions had been made.

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. Deprivation of liberty authorisations had been sought. Staff understood the principles of the Mental Capacity Act and understood what a DOLs authorisation was. A member of staff told us that people were supported by the staff in the community and DoLS applications had been made for people subject to continuous supervision. We discussed the use of sensors and monitors with the registered manager. They confirmed these restrictions were not detailed in the DoLS applications and said this was because the original applications were requested some time ago and were outstanding. It was stated that where changes to DoLS applications were taken the supervisory body (local council or health trust) was informed by phone.

Decision making profiles and register of decisions gave staff guidance on specific decisions people made and who helped them with more complex decisions. The decision making profiles detailed the decisions the person was able to make and the process to be followed for more complex decisions. For example, one person made visual choices from options given and to show refusal the person will walk away.

Staff told us how they enabled people to make choices and explained how people made staff aware of their decisions. A member of staff said some people moved away from the individual or group activity offered to show their preference for an alternative activity. They said some people made choices from two visual options given while others made choices of clothes to wear by the feel of the texture. However, care plans were not clear on the assistance with choosing clothes where people needed additional support from staff to make decisions about what they wore. A member of staff said people's capacity was assessed and where

people lacked capacity they supported the person with informed decision making.

The documentation in place showed how some decisions had been reached and who had been involved in the process. We saw the mental capacity assessments for one person had identified them as lacking capacity to make decisions about dental care under anaesthetic. The best interest decision taken involved the dentist, relatives and registered manager. The decision for dental treatment was reached by the dentist and the consequences of not having this procedure were documented. We saw for some people a mental capacity assessment was undertaken for routine screening. Where the person was assessed as lacking capacity the best interest decision was taken by the GP with the involvement of the registered manager and the relatives. This meant the best interest decision reached was for the person not to have routine screening.

Staff had the knowledge and skills to carry out their roles. Staff spoke positively about the quality and quantity of training they had access to. A member of staff said there was a combination of online and face to face training. They said online training recently attended included attitudes and behaviours, Management of Actual or Potential Aggression (MAPA) for staff to manage aggression in a calm way which keeps everyone safe and the organisations values training. There was other training for staff to attend and included dementia awareness. They said some specialist training to be attended was to enable staff to support people whose relatives were diagnosed with a degenerating metal heath condition.

The analysis of training we saw indicated that 97% of staff had completed mandatory training set by the provider which included safeguarding of vulnerable adults from abuse, Health and Safety at work, and infection control. The staff had also attended Company Requirement training which included moving and handling, equality and diversity and autism awareness.

A bank worker told us they felt prepared for their role and their induction included shadow shifts and one to one supervisions with the registered manager and senior support worker. They said during this period they read policies and procedures, care plans and attended mandatory training set by the provider.

All staff said they received regular one to one supervision with their line manager. Staff said supervision was three monthly and during these meetings they discussed concerns, people at the service and training needs. They said there were opportunities to discuss their welfare and wellbeing during the meetings. A member of staff said one to one supervision followed an agenda which included the progress on the action plan from previous meetings and issues from staff meetings. Staff also said they had annual meeting where performance was discussed and action plans developed on their personal development.

We saw refreshments were offered regularly and between meals healthy snacks were served. Three weekly rolling menus were devised by the staff based on people's preferences. A member of staff said the menus were developed to reflect the seasons and a record of menu changes and alternatives was maintained. This member of staff told us people's likes and dislikes and the alternatives served when the person disliked the meal on the menu. There was a wide range of fresh fruit and vegetable, snacks, tinned and frozen foods for people to have enough to eat and drink and was healthy.

People had access to ongoing healthcare. Staff said they organised appointments and accompanied people on these visits. A member of staff said the GP trusted the staff judgements and acted on their observations of people's health.

Health action plans included an assessment of the person's health and wellbeing and the action plan listed the steps that must be taken in order to achieve a specific goal. The action plan clarified the resources needed to reach the goal. The health action plan for one person included the advice from Speech and

Language therapist (SLT) on the textured diets to be served, the sitting position to assist the person with eating and the adapted cutlery to be used. We saw staff followed the guidance with the meals they served the person. For example, brown bread without crusts and in bite size pieces.

Hospital passports listed the social and healthcare professional involved in the care of the person, known allergies and interventions from staff for people with epilepsy. The things that were important to the person were included for medical staff in the event of an admission to hospital. Records showed staff recorded the appointments which included routine check-ups and the outcomes of these visits.

Profiles and management plans for people diagnosed with epilepsy were in place. Epilepsy intervention plans were in place and gave staff guidance of each type of seizure, the support needed from staff, the actions for prolonged episodes and when medical assistance was needed.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. We saw some positive interactions between staff and people using the service. Staff knew people's needs well and there was a calm and friendly atmosphere.

When people showed signs of distress we saw staff distract the person with an activity. For example foot spa's and suggesting the person go to their room where there was a calmer space. On another occasion and for another person distraction techniques were also used by other staff. A member of staff said "XX come and help me sort out the shapes" and when the person was successful the member of staff cheered. During our visit we saw people were sitting in their preferred position which included on specialist foam mats. We heard staff sing with one person and their laughter indicated enjoyment with the activity.

Staff showed concern for people's well-being. A member of staff said they took time to know the person and trust was achieved with having continuity of staff that people knew. They said "[trust] comes from both sides. They trust us and we trust them". This member of staff also said people were kept informed about the day's schedule. Another member of staff said people at the service did not communicate verbally but made staff understand "how they are feeling. We talk things through and explain the tasks which make them feel secure, discuss with staff our observations we keep trying until people show us they are happy".

A member of staff said "people are able to let [us] know their preferences and these are recorded in their care plans. New staff shadowed more experienced staff to ensure the care people received "was the care they had come to expect".

Personal details and profiles gave guidance to staff on people's relationships with family and friends, their likes and dislikes and preferences on how personal care was to be met. The one page profiles included "what is important" for example maintaining contact with family and activities and the support people needed from staff to maintain contact with family. The Relationship map was a visual form for staff on the important relationships and connections to the person. For example family, other people living at the service and paid support.

Information on advocacy was pinned on the notice boards within the home and accessible to staff and visitors.

People's rights were respected and staff explained how these were observed. A member of staff said people were treated as individuals, they [staff] explained the consequences of the choices available and respected people's decisions. Another member of staff said "we respect people's privacy and dignity. Close doors during personal care and give people time to be on their own".

Requires Improvement

Is the service responsive?

Our findings

Care plans although person centred and reviewed annually were not monitored in between reviews to assess their effectiveness. The registered manager said updates on actions were recorded on workbooks monthly; however this was not translated into the care plan. For example, documentation showed one person was experiencing a deterioration of their vision and needed assistance from staff to move around the home. An assessment of needs regarding this person vision to then develop support guidance did not take place. While we accept the decision was to wait for a diagnosis before devising the care plan an assessment and care plan was not developed on how to support the person in the meantime.

Staff told us the frequency for reviewing the needs of people. A member of staff said care plans were done "as a team. Changes are discussed." They said meetings to review people's needs were three, six monthly and yearly." Another member of staff said the registered manager "mostly wrote the care plans" and where people's needs changed "we tell the [registered] manager what needs changing [in the care plan].

We recommend the service seek advice from a reputable source to ensure that care plans are reflective of the varying support needs of the people receiving care.

Workbooks were used by staff to record accounts of daily events. Daily activities undertaken included the times people woke, food and fluid intakes and activities.

The people living at the service were not able to tell us about the care they receive and the approach used by the staff to deliver personalised care. Life stories included people's background histories, education, family relationships and how staff were to support them with maintaining contact. This meant staff supported people with maintaining the relationships that were important to them.

A typical day care plan described people's preferred times to rise, how staff were to support the person with their personal care routines and how staff were to enable the person to participate in their hygiene routine. Other schedules that shaped the person's day included their eating and drinking regimes and night time routines. For some people the distraction techniques needed for staff to gain their consent to carry personal care was detailed in the care plan.

The Communication care plan for one person included an overview which included the common words used and their level of understanding and the preferred first name staff were to use. A guide of words, their meaning and the staff response was included for example, ignoring staff, indicated refusal of the activity and staff were to keep calm and respect the decisions.

The eating and drinking care plan for one person stated the menu was devised by staff and was on a three week rolling rota. It was documented that staff were aware of the person's likes and dislikes. The action plan listed the assistance needed by the person to eat their meals and for staff to monitor their weight due to potential weight gain from prescribed medicines. The behaviour care plan for the same person identified the person to be risk in the community and staff were to accompany the person. Staff were aware of how to

distract the person with an enjoyable activity where unacceptable behaviours were presented. On occasions this person had injured themselves intentionally and staff were guided to reduce this risk of this when the person was anxious by sitting next to them and to distract them with singing. This meant the staff were able to follow the guidance in place for some people that needed assistance with meeting their identified needs.

Staff said the programme of in-house and community activities had improved within the last 12 months. A member of staff said people were going out regularly and visits to places of interest were organised. There were in-house activities which included time in the sensory room designed with lighting, music and objects to help individuals develop and engage with their senses and games. The registered manager told us there was a weekly activities board and staff organised activities based on people's preferred activities. For example, shopping music and playing skittles.

The activities board included people's schedule of daily activities. We saw people went on outings, had picnics and visits to garden centres for coffee were organised. During the inspection a member of staff was supporting one person with a pamper session. The member of staff told us the person enjoyed pampering sessions.

There were no complaints received at the service from relatives since our last inspection.

Good

Is the service well-led?

Our findings

At the previous inspection dated January 2017 we found a breach of Regulation 17. We found records were not personal and confidential to each person. Care plans and risk assessments were not developed for all aspects of people's care and treatment needs and to minimise the risk to people safety and health. Quality assurance systems were not effective as action plans were not developed where gaps in the fundamental standards were found. The provider wrote and told us how the breach of regulation was to be met. At this inspection we found actions had been taken to improve records and quality assurance systems.

Quality assurance systems were in place. A visit from the quality assurance team took place quarterly and from the recent audit undertaken the service was rated 89.6% above the average rating of 75%. Where shortfalls were identified an action plan had been developed. The action plan included improving the environment, activities and training and listed the staff responsible for meeting each action. Annual service reviews by the registered manager, audits from commissioning visits and quality assurance action plans were combined into a consolidation action plan. The progress made to meet the action plan was monitored by the registered manager and operation manager.

Whilst quality assurance systems were in place, these were not always effective. The provider and registered manager had not identified the concerns around care plans that we highlighted during the course of this inspection.

Accidents and incidents involving people were recorded and reviewed by the registered manager. There was a centralised electronic system in place which documented the type of incident, who was involved and the actions to take including any follow up actions. The registered manager said senior managers had access to the care management system for assessing the level of risk of harm to people and to identify patterns and trends.

A registered manager was in post. The registered manager told us they used a strong but fair and respectful style of management. They said "I challenge in a positive way" and there was "a commitment to people while ensuring the outcome is positive". It was also stated "sometimes changes that are not popular have to be made. [I] explain to the staff and once explanations are given staff are more accepting to the change". The registered manager said it was important to "keep striving for the best that it [service] can be. They [people] are the centre and sometimes you lose sight that it's for three people."

The views of people were gathered at meetings known house meetings and by surveys. Surveys were sent to people, relatives, staff and social and healthcare professionals. The analysis from July 2016 had been sectioned into areas that were working well and the areas that were not working well. The feedback was generally good and included meeting the healthcare needs of people and areas for improvement included better communication from staff and developing activities for people. The registered manager told us this feedback was discussed at team and at meetings for people known as tenant meetings.

Staff said they felt well supported by the registered manager. A member of staff said the team worked well

together. They said the registered manager had management responsibilities for two other locations and a rota was in place which identified the days the manger was working at the home. This member of staff also said that the registered manager was contactable by phone on the days they were not on duty at the home.

Another member of staff said the team was stable. "We don't always agree, we work together, we don't get offended. Fresh eyes are good. I tell the staff say if you think there is a better way. We sort it out. The main goal is the people we support." They said the registered manager was "very supportive, she knows my main priority is the people we support. I will say and have said it." A bank worker told us the team "was lovely and worked hard. We support each other. We ensure activities take place."

Staff said they attended regular staff meetings. The registered manager said there were between six and 12 team meetings per year. There was an expectation for staff to read and sign the minutes to indicate agreement with the decisions made and to ensure they were aware of the information shared. A read and sign folder of weekly updates which included policy changes, safety alerts and human resources (HR) pay and condition procedures. A bank worker told us the read and sign file kept them informed of changes.