Hestia Housing and Support

Harwood Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 and 5 May 2016. Harwood Road is registered with the Care Quality Commission to provide care and accommodation for up to 15 men and women with mental health needs. At the time of our inspection there was one vacancy.

There are 13 bedsits, which provide kitchen facilities and en-suite bathrooms. Additionally, there are two single occupancy bedrooms with a shared kitchen and bathroom. Communal areas include a lounge, a separate dining room and activities area, a main kitchen, laundry room, and a small courtyard and garden at the rear of the premises. There are offices which people can use for private meetings. The building comprises four storeys and does not have a passenger lift.

The service had a registered manager in post, who had worked for the provider for several years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the registered manager was based at another local registered service run by the provider and was not actively involved in the daily management of Harwood Road. The provider confirmed that they were in the process of applying for the service manager to be registered by the Care Quality Commission to manage the service.

At the previous inspection in September 2015 we found three breaches of regulation and made one recommendation. The provider had not informed the Care Quality Commission of significant events in the service that impacted on the safety and wellbeing of people who used the service. People's safety had not been properly ensured due to the non-completion of some fire prevention measures and inconsistent practice with the management of medicines. The provider had not documented how they addressed people's healthcare needs and preferences in a person centred way within their care plans. We made a recommendation for the provider to seek guidance about how to support people to use their food budget to purchase and prepare balanced meals.

Following the inspection the provider sent us an action plan which highlighted the action they would take in order to improve. At this inspection we found the provider had met the three breaches of regulation and achieved sustained improvements in regards to the recommendation.

Staff were properly recruited and although there were sufficient staff to support people to meet their needs, we noted that a significant proportion of the staff team comprised regular bank staff and agency workers. The provider demonstrated that this issue was being addressed through recruitment initiatives, so that people could benefit from building longer-term relationships with a stable staff team.

Staff understood how to protect people from abuse and the provider notified relevant authorities. Risks to people's safety and wellbeing and actions to mitigate these risks were not clearly identified at all times.

Appropriate arrangements were in place to support people to safely take their medicines and access healthcare services. Records showed that people were consulted about food choices, supported to get involved with food preparation and cooking, and encouraged to eat a healthy diet.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. The service manager and the staff team understood and adhered to the principles of upholding people's human rights in line with legislation.

People were supported by staff who had suitable training to meet their identified needs. Staff were observed to demonstrate a caring approach and were respectful towards people. Some improvements had been made to the premises so that people could enjoy a welcoming and comfortable home environment that promoted their dignity, however, this work was still ongoing.

People's needs were individually assessed and they were consulted about their needs and wishes. Care plans showed that people were involved in setting objectives for their recovery and reviewing their progress. People told us they were asked for their views about their care and support, and were provided with information about how to make a complaint.

The provider worked in an open way with people and their relatives, for example through sharing information at residents' meetings and seeking the views of people and their relatives about the quality of the service at review meetings. People and staff told us that the service had improved due to the leadership of the service manager and clear systems were in place for monitoring care practices and record keeping.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Staff were aware of how to safeguard people and report any concerns about people's safety and welfare.

Risks to people's safety and wellbeing and actions to mitigate these risks were not clearly identified at all times.

Suitable arrangements were in place to support people to take their prescribed medicines.

There were enough staff to meet people's needs; however, the stability and continuity of care for people was not consistent due to the shortage of permanently employed staff.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and support for their roles and responsibilities.

Staff had some knowledge about their responsibilities under the Mental Capacity Act 2005 (MCA) and people were asked for their consent in accordance with legislation.

People were supported to eat a healthy diet and improve their cooking skills.

Systems were in place to support people to access professional healthcare appointments and guidance.

Is the service caring?

Good

The service was caring.

People had developed positive relationships with staff and were supported to make decisions about the running of the service.

Improvements had been made to the environment to provide people with more comfort and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were individual and focussed on people's needs and wishes.

People were offered meaningful social activities at home and in the community.

People knew how to make a complaint and were confident that any concerns would be fully responded to.

Is the service well-led?

Good

The service was well-led.

People and the staff team were positive about how the service was managed.

Effective record keeping practices had been implemented to support the smooth running of the service.

Systems were in place to monitor the quality of the service, which included protocols to seek and act on people's views.

Harwood Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the registered 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.

The inspection took place on 4 and 5 May 2016. The inspection was unannounced on the first day and we informed the service that we would be returning on the next day. The inspection team comprised one inspector and a specialist professional advisor, who was a registered mental health nurse.

Prior to the inspection we reviewed information we held about the service. This included notifications of significant incidents we had received. Notifications are events the provider is required by law to inform us about. We also looked at the last inspection report of 16, 17 and 24 September 2015.

During the inspection we spoke with five people who used the service and one relative, two support workers, one senior support and review worker, the interim team leader and the service manager. We spoke with a visiting support worker from a local advocacy organisation for people with a learning disability and received comments from a visiting health and social care professional.

We read four care plans and the accompanying risk assessments. We checked a variety of documents including medicine administration record (MAR) charts, five staff records, the complaints log, minutes for residents' meetings and staff meetings, quality assurance audits, policies and procedures used by the provider, and health and safety records. We also observed the support and care provided to people in the communal areas and viewed the premises.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we found that the provider had not informed the Care Quality Commission (CQC) about safeguarding allegations, which is a legal requirement in order to enable us to take appropriate action where required. At this inspection we noted that the provider was clear about their responsibilities and had appropriately notified us as required.

At the previous inspection people told us that they did not always feel safe because a small number of people who used the service had allowed acquaintances to visit at night time. One person said, "It is a lot better now, [the service manager] has made changes and people just can't walk in off the street" and another person commented, "The staff make sure we are safe and the house is now secure." A relative informed us they were pleased that the problems last year with intruders gaining access to the property had been resolved. The provider had implemented a range of measures last year to protect people who used the service and staff, which included increased staffing during the night-time in order to prevent people from gaining access to the building. At the previous inspection we found that the provider had increased the staffing levels to two waking staff at night-time. The service manager had informed us that there were plans to eventually reduce the night-time staffing levels to one waking staff member and one sleeping-in staff member, who could be woken if additional support was needed. We were assured that any such changes to staffing levels would be subject to a thorough risk assessment. At this inspection we noted that the staffing arrangements had now been reduced to one waking staff member and one sleeping-in staff member. Records demonstrated that the problems due to intruders at night-time had now been resolved, which people and staff confirmed.

People who used the service told us they felt safe with staff. One person said that staff ensured that people were not bullied or harassed by other people who used the service. We observed a relaxed atmosphere and saw that people readily approached staff to speak with them or ask for support. Staff had received training about how to identify different types of abuse and how to report any concerns. Staff understood the provider's safeguarding policy and procedure, and were familiar with the whistleblowing policy. (Whistleblowing is when a worker reports suspected wrongdoing at work).

At the previous inspection we saw that fire drills were being carried out monthly, weekly fire alarm checks were made and there were evacuation plans for people who did not have sufficient mobility to evacuate the building without staff support. Records showed that staff spoke with people during residents' meetings and key working sessions about the importance of fire safety. However, we had found that there was insufficient evidence to demonstrate that all necessary elements of fire safety had been properly addressed. We had been informed that nine people smoked in their bedrooms, which were supplied with fire retardant bedding, ashtrays with a lid and fire detectors linked to the fire alarm in their rooms. The most recent fire risk assessment had been completed in June 2015, however we noted that the action points raised in the 2014 fire risk assessment had not all been actioned. This included the need for fire doors to be upgraded, instructions at call points, carbon dioxide detectors to be installed by the boiler and fire doors being propped open. The service manager told us they would follow up on this. At this inspection we found that the provider had completed all necessary actions identified in their fire risk assessment. Arrangements had

been made for a fire safety officer to come to a residents' meeting and talk with people about fire prevention. The senior support and review officer told us that they hoped the session would support people to consider risks when cooking or smoking, and enable them to inform staff if they detected possible fire risks within the premises.

Records showed that the provider ensured people were provided with a safe living environment. We looked at a range of health and safety documents and check lists, which included annual portable electric appliances testing, annual landlord's gas safety check, daily checks of the temperatures of fridges and freezers, weekly emergency lighting checks, weekly fire call point tests and three monthly fire drills. Bedrooms were equipped with window restrictors and checks were made that they were in good working order.

At the previous inspection we noted some areas for improvement during our observation of the morning medicines round. We had observed that people were supported to take their medicines in a busy main office adjacent to a door that staff entered and left the building through, which appeared to be a distracting environment for staff to focus on correctly administering medicines. At this inspection people now received their medicines in a quieter office on another floor.

Medicines were administered by two members of staff in order to reduce the risk of any mistakes occurring. At the previous inspection we observed that one member of staff had correctly signed the medicines administration record (MAR) chart for the morning medicines, another member of staff had signed for the lunchtime medicines that had not yet been administered. We had observed that although medicine audits had been carried out they were not signed to show the identity of the auditor. During this inspection we checked the management of medicines with a senior support and review worker. They told us that all support workers had received medicines training from the supplying pharmacy but had not been issued with certificates. We discussed this with the service manager, who told us they would ask the pharmacy for certificates so that the provider had clear records about the training staff had undertaken. The MAR charts we looked at were clearly written and signed correctly by staff. Audits were carried out every month by the senior support and review worker and the team leader, and were appropriately signed.

We found that the provider now demonstrated that there were systems in place that supported staff with their role and responsibilities in relation to supporting people with their medicines. For example, the supplying pharmacy visited the service to check the storage and administration of medicines, and provided advice if staff had any queries. People's medicines were reviewed by their doctor every six to eight weeks, and at the time of the inspection one person was managing their own medicines.

At the previous inspection we had identified that the risk assessments were not always person-centred and they needed more information about how to mitigate the identified risks. At this inspection we found that risk assessments were more thorough and contained measures to support people to take balanced risks and maintain their independence. Risk management plans had been developed to provide staff with guidance to support people in specific circumstances, for example if a person presented behaviours that challenged the service. We had noted at the previous inspection that there was a care plan in place for a person who needed support to meet a personal care need. The support was provided by staff from an external agency but there was no information about how the service would manage potential risks, such as external staff not turning up. We noted at this inspection that this information had not been acquired, which meant the person was potentially at risk of not receiving the care and support they needed. The service manager informed us that they planned to contact the person's relevant healthcare professional for written guidance to include in the care plan and risk management plan.

People told us that they thought there were sufficient staff on each shift to meet their needs. People said that staff were available to chat with, accompany them to hospital appointments in line with their needs and/or wishes, and support them with daily living skills. At the previous inspection we observed that there were not enough permanent staff in post and the provider used a significant number of bank staff and regular agency staff. The service manager had informed us that the provider was currently recruiting for new support staff and interviews were in progress. At this inspection we observed that there was still a noticeable use of bank staff and regular agency staff, but the staff used had been at the service for a long time which minimised the impact of difficulties in recruiting permanent staff. The service manager told us that the recruitment had not been as successful as hoped for and another recruitment drive was due to take place.

Staff files showed that recruitment was carried out safely. The files we looked at showed that a minimum of two references were obtained and their authenticity was checked upon. There was also evidence of staff's entitlement to work in the UK, proof of identity and address. Disclosure and Barring Service (DBS) checks were conducted before staff commenced employment. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Any gaps in a candidate's employment history were explored and documented.

At the previous inspection we observed that the provider had risk assessed the premises, in order to prevent people without authorisation from entering the premises. This risk management plan involved carrying out some physical changes to the premises, and the implementation of protocols for promoting the safety of people and staff. These measures included the installation of an upgraded close circuit television (CCTV) system with more cameras and the front door buzzer was deactivated so that any calls to enter the building need to be checked by staff, who will physically open the door, if appropriate. The fire doors had been alarmed to prevent people from leaving them open, which was previously providing entry routes for people without authorised access to come in to the premises. At this inspection we found that these safety measures were still in place. We observed that an intruder attempted to enter the building on the first day of this inspection and the situation was managed calmly and effectively by staff. The service manager explained that the building's position in front of a bus stop close to a busy high street meant that potential intruders were sometimes in the vicinity if a person momentarily left the front door open.

Good

Is the service effective?

Our findings

At the previous inspection people had told us they were provided with support to access healthcare services, including visits to dentists, doctors, opticians and community psychiatric nurses. We had looked at emails sent by staff to healthcare professionals, which showed that staff informed relevant professionals about any changes in people's health and reported if people were not following prescribed healthcare guidance. However, we had noted that people's individual files did not always reflect the support provided by staff to meet their healthcare needs.

At this inspection we found that improvements had been made to people's care plans and there was now clear information about how people were being supported to meet these needs. We saw that people were supported by staff to attend medicine reviews, dental appointments and meetings with community psychiatric nurses. People's care plans showed that their healthcare needs were reviewed annually by community healthcare professionals and the Care Planning Approach (CPA) review meetings were also used to discuss and monitor people's health. (CPA is the system used to organise people's mental health services, involving people, their representatives and health and social care professionals). The CPA meetings were attended by staff from the service, which provided people with emotional support and enabled staff to contribute their observations. We spoke with a health and social care professional during the inspection who expressed positive observations about how people were being supported to meet their healthcare needs.

People using the service were complimentary about the support they received from the staff. One person told us, "I can speak with staff if something is troubling me" and another person told us, "They are supporting me to learn how to cook as I want to move on to a flat of my own." A relative told us that their family member spoke favourably about the support they received and did not want to live at any other service.

Staff told us they were offered useful training opportunities, which included training to meet the specific needs of people who used the service. Records showed that staff were provided with mandatory training which included fire safety, infection control, health and safety, equality and diversity, and food hygiene. Staff had also received training about understanding mental health needs, drug and alcohol awareness, personal safety and domestic abuse. Staff told us that the domestic abuse training was interesting and helpful as people who used the service might have experienced domestic abuse in the past and were at risk of developing new relationships and friendships with people who could be abusive to them. The service manager told us that all staff were being enrolled on the Care Certificate, which is national set of standards for all staff new to care, as it would provide a beneficial refresher for more experienced staff.

At the previous inspection we found that the records for formal one-to-one supervision showed that there were periods when supervision sessions did not occur at least bi-monthly. The provider had established a new schedule and we saw evidence that some supervision had taken place in the previous month and others had been arranged to take place shortly. At this inspection we found that staff were receiving regular supervision and an annual appraisal. This demonstrated that there were structured systems in place to

support staff with their learning and development, and enabled staff to speak on a one-to-one basis with their line manager about the needs of people they supported and their own performance.

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

Staff demonstrated an appropriate knowledge of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act 1983 (MHA). Appropriate documentation was in place for people who were being supported in line with treatment orders and other sections of the MHA. The service manager confirmed that there were no DoLS authorisations in place at the time of the inspection.

At the previous inspection we received some mixed responses in relation to whether people thought they received appropriate support to meet their nutritional needs. People had told us they attended menu planning meetings but thought the menus lacked variety. Three people stated they would like more opportunities to learn to cook. Although a dietitian had visited the service and provided nutritional guidance and advised people about healthy eating, we had found limited information in people's care plans about how they were supported to meet their individual nutritional and hydration needs.

We noted at this inspection that there had been further input from a dietitian and a focussed approach by staff to encourage people to adopt healthier eating habits. For example, people were able to help themselves to a selection of fresh fruit every day, which was available in the main kitchen and presented on platters in the lounge. Healthy eating was discussed at residents' meetings and people were encouraged to think about how they could incorporate healthy eating principles into their daily diet. People told us they were now getting more involved with food preparation and cooking with support from staff. One person told us, "I do some cooking in the week but the best meal is on Sunday when I get a roast." Another person told us they felt they were building up the skills they needed to live in their own flat, including food budgeting and cooking.

Good

Is the service caring?

Our findings

People spoke positively about their experiences of living at the service and the support they received from staff. One person told us, "We do more things now with staff, they ask us what we like. I have been bowling and to the cinema" and another person said, "The staff are very friendly, very understanding and very caring. They support me to tidy my room twice a week and encourage me to get involved in groups." A relative told us, "The staff are friendly with [my family member]. They are welcoming and keep me informed."

At the previous inspection we noted that care plans did not always reflect people's individual needs, although we observed that staff had a good knowledge of people's wishes, likes and dislikes, and responded to people's requests. At this inspection we found that the care plans were written in a more personalised way which mirrored the good rapport and sociable interactions we observed between people and staff.

At the previous inspection we noted that people were not always supported in a way that maintained their dignity, due to problems with the premises. We had observed that parts of the premises including people's bedsits and bedrooms needed improvement. The provider had provided us with documents which evidenced that requests for refurbishment and environmental improvements had been discussed with the housing association that owns the property. At this inspection we found that improvements were being achieved in communal areas, for example lounges had been decorated and the finances for the complete refurbishment of the main kitchen had been agreed. The progress with improving the bedsits and bedrooms was occuring at a slower pace, although we observed a staff member accompanied by a decorator consulting with people who used the service for planned work to these areas.

At the previous inspection people and staff told us about the visiting restrictions that had been implemented to provide a safer environment for people, their visitors and staff. These restrictions meant visiting was allowed between 11am and 8pm, and personal visitors who were acquaintances or casual friends were required to conduct their visits in communal areas. People confirmed they had been consulted about these changes. At this inspection we found that some people wanted a more flexible approach to be introduced, to enable a partner or close friend to stay over. People and staff told us that this was being discussed in residents' meetings so that people could find ways to relax the current arrangements without compromising everyone's safety. The minutes for residents' meetings demonstrated that this was one of the many topics that people were asked for their views about, which showed that the provider valued and acted on people's opinions.

People had access to advocacy services and were supported to contact their care coordinators at the community mental health team. We noted that information was made available for people about different advocacy providers, for example advocacy for people with mental health needs and for people from minority ethnic backgrounds. People's personal information was securely stored in the staff office and staff were aware that people's personal details must only be shared with individuals or organisations that had a right to access such information.

Good

Is the service responsive?

Our findings

At the previous inspection we received some mixed responses from people in regards to whether they were supported to contribute to the development and reviewing of their care plans. Some people had told us they wanted to be supported by staff to acquire more skills so that they could move on to more independent living arrangements. We had observed that although the care plans appeared to be task orientated and generic, and did not fully address areas including people's physical health care needs, capacity and consent, promoting smoking cessation or management of risks for people who smoked, and medicines, their efficacy and side effects.

At this inspection people expressed that they felt more involved in their care. For example, one person told us about a walking group that had been established since the previous inspection. The person explained that staff had talked to them about how the group could benefit their physical health needs, and impact on issues including isolation and boredom. We noted that people's long-term plans differed in accordance with factors such as mental health and physical health care needs, age and own aspirations. Another person told us about their long-term plans and confirmed that they were able to have discussions about their future during one-to-one meetings and care planning review meetings with their allocated staff member, known as a key worker. A third person told us they had been encouraged by staff to look at the known health and wellbeing benefits of smoking cessation but had not felt ready to pursue this.

People's needs were assessed before they moved into the service. The pre-admission assessments were conducted by people's health and social care professionals, and additional assessments about people's daily lives, routines and activities were carried out by staff at the service. At the previous inspection we were informed that the needs of people who used the service was being reviewed by the provider in conjunction with the relevant community care co-ordinators, as it had become clear that the service was not suitable for some people who lived there. At this inspection we found that following the completion of the joint assessment work, some people had been supported to move on to other types of accommodation that met their identified needs. The provider told us this meant staff could focus on improving the quality of care and support for people whose needs were in line with the service's objectives.

The provider used a clinical tool known as the Mental Health Recovery Star management plan. This is a system designed for people managing their mental health and recovering from mental illness, which addresses key areas including mental and physical health, social networks, relationships, identity and self-esteem. At the previous inspection we had noted that although people told us they attended meetings with their key worker there was limited evidence that these meetings took place and some of the Mental Health Recovery Star plans were not up to date. At this inspection people told us that they received individual support time from their key worker and records evidenced it. This showed that the provider actively attempted to engage people and support them to evaluate their mental health needs and recovery.

People told us that they were offered support to access community resources and take part in social activities. We met a person who had been out to their weekly kick boxing session and other people told us they went to the gym. One person said that staff encouraged them to visit local places of interest that

offered free admission or low cost entry fees, for example art galleries, exhibitions and museums. Staff encouraged people to participate in the activities programme at the service, which included cookery classes, a gardening group, indoor games and quiz evenings, film night with soft drinks and popcorn, and table tennis. At the time of the inspection new equipment had been ordered for table tennis, which people and staff told us was very popular. A health and social care professional told us that the staff had supported a person to access voluntary work and that another person had been encouraged to attend a college course. The health and social care professional commented that staff were able to support people who had previously lacked motivation to get involved in meaningful community activities.

People told us they knew how to make a complaint and thought any complaints would be dealt with properly. The provider had a complaints policy and procedure in place. The provider's complaints guidance for people correctly stated that people could inform the Care Quality Commission (CQC) about any concerns, but did not specify that the CQC does not investigate individual complaints. The provider addressed this finding during the inspection and issued people with a more comprehensive complaints guidance leaflet. The senior support and review officer told us that the new complaints guidance would be put on the agenda for residents and staff meetings, so that people and staff were fully aware. The complaints log showed that complaints were addressed within agreed timescales and staff spoke with people to explain the outcome if they made a complaint.

Good

Is the service well-led?

Our findings

At the previous inspection people had told us they felt they could informally approach the service manager and staff had told us they felt better supported because the provider was addressing one of the priority issues of preventing unauthorised persons from entering the premises, in order to minimise risks to people using the service, their visitors and staff. We had observed that although the service manager has been in post for a few weeks, they had already introduced new approaches to improve the quality of the service. At this inspection we found that the provider had achieved significant improvements, although the issue of finding permanent staff had not been resolved. People told us they thought the service was well managed and there were positive comments made about the service manager and the senior staff. One person told us, "It is better since [service manager] here, he has sorted out the trouble at night time and the food's better" and "[Senior support and review worker] is good and sorts things out for me when he's in charge of the office."

Staff stated that they thought the service had improved and now there was effective leadership and management. The service manager was described by staff as being "committed" and with a clear vision, shared with people and staff, about how the service needed to continue to improve. The service manager told us that they were in the process of applying to the Care Quality Commission for registered manager status. The service manager was responsible for three local services run by the provider. Therefore the daily management of Harwood Road was undertaken by a team leader, with the service manager spending approximately two days a week at the service. At the time of the inspection the service employed an interim team leader and we were advised that the permanent position was due to be advertised.

At the previous inspection we found some concerns in regards to the provider's record keeping which could have impacted on the efficient and safe management of the service. These records had included daily testing of fridge and freezer temperatures and cooked food temperature probes. At this inspection we did not identify any concerns with record keeping.

The provider demonstrated a range of systems were used in order to monitor the quality of the service. The service manager told us that they turned up at the premises when they were not expected by staff, which included early mornings and weekends. Discussions with the service manager indicated that any observations made during these visits of staff not performing in line with the provider's expectations were dealt with through supervision. An annual monitoring visit was carried out by the provider, which included a person who used Hestia Housing and Support services at a different location. As this inspection was carried out nine months after the previous inspection, the most recent monitoring visit report had already been viewed by us and was noted to have been detailed and clear about the improvements needed. A person who used the service told us they had been asked to, and was looking forward to attending a training course so that they could participate in monitoring visits at other locations. They also explained to us their role as the residents' representative at staff meetings, which enabled them to feedback to the service manager and staff team the views of people who used the service about a variety of issues, including the quality of the care, support and accommodation. A relative confirmed that they were asked for their views through questionnaires and at review meetings.