Nadali Limited

Sussex House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 15 March 2018 and was unannounced. At the last inspection in February 2016, the provider was rated Good overall and a recommendation was made in relation to developing the activity programme.

Sussex House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service provides support for adults who have mental health conditions and accommodates up to 24 adults. At the time of our inspection there were 21 people whose needs were predominately mental health, using the service. The service offers a range of ensuite rooms over three levels. There are also two communal lounge areas, a dining room, an activities room, a kitchen, bathroom and toilet facilities, independent skills kitchen area and outdoor courtyard.

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.

Some areas of the environment posed a potential risk to people. These included, a bottle of cleaning fluid left on the kitchen hatch and a box of disposable gloves left out in a bedroom, accessible to people who used the service, without any risk assessments in place to mitigate these risks. Individual risk assessments did not always identify the level of support people required. We have made a recommendation about risk assessment and management.

People who used the service had an assessment of their needs, risk assessments and a care plan. There was an inconsistency in the care files with some people having informative care plans for specific areas, whilst others contained less detailed information. The registered manager was in the process of transferring care plans to a new format which contained more detailed information. Similarly, we found that although risk assessments were completed, they did not always identify the level of support people required. We have made a recommendation about updating the information in care plans. The service was undergoing a refurbishment. The provider shared with us further plans to provide a kitchenette for people to practice their independence skills and refurbishment of the garden.

There was a quality monitoring system in place, which consisted of audits, checks, surveys and meetings. This was not fully effective in identifying the issues we found. We have made a recommendation about this.

Staff had completed training and knew how to safeguard people from the risk of harm and abuse. Medicines were managed safely and administered to people as prescribed.

Staff were recruited safely and in sufficient numbers to meet people's needs. Staff had access to induction, a range of training, supervision and support. This provided staff with the necessary skills when providing support to people.

Staff had a kind and caring approach. They knew people's needs very well and supported them to maintain independence, privacy and dignity. Staff supported people to make decisions in order to maintain their human rights. They ensured that when people lacked capacity, they included relevant people in best interest decision-making.

People's health care needs were met and they had access to community health care professionals when required. The registered manager and staff team had developed good working relationships with health colleagues. This had resulted in planned discussions about treatment options. People's nutritional needs were met. Menus provided them with choices and alternatives. Staff contacted dieticians and speech and language therapists when they had concerns.

There was a range of meaningful occupations and activities for people to participate in and planned visits to local facilities provided.

The provider had a complaints policy and procedure and staff knew how to manage complaints. Relatives told us they felt able to raise concerns if required. All of the people and relatives we spoke with described an open culture and accessible management.

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.

People received their medicines as prescribed. Staff knew how to safeguard people from the risk of abuse and where to raise concerns when required.

There was a robust staff recruitment process and sufficient numbers of staff employed to meet people's needs.

Known risks were recorded.

Is the service effective?

Good

The service was effective.

People who used the service, were supported by staff who had received essential training in how to effectively meet their needs. Staff received regular supervision, support and appraisal.

Staff understood the principles of the Mental Capacity Act 2005 (MCA), which meant they promoted people's rights and followed least restrictive practice.

People were supported to maintain their health and well-being and had access to healthcare professionals and services. Staff encouraged people to have meals of their choice.

Is the service caring?

Good

The service was caring.

People told us they were well cared for. Staff had developed both positive and caring relationships with people and were seen to respect their privacy and dignity.

Staff were knowledgeable about the support people required and their preferences for how their care and support was delivered. People were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were knowledgeable about people's individual needs although not all this information was included in care plans.

People had assessments, care plans and risk assessments in place. There was an inconsistency in the quality of these documents and more work is required to ensure they include up to date guidance for staff.

The registered provider had a complaints policy and procedure in place. People told us they would be confident in raising any concerns they had and knew how to make a complaint.

People had access to meaningful occupations and activities. These included those arranged in the service and those accessed in the local community.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a quality monitoring system, the environmental audit had not been sufficiently robust to identify risks and areas to address. When issues had been identified, there had been a delay in addressing them.

The culture within the organisation and in the service was described as open and honest. The registered manager had developed good working relationships with the staff team and other health and social care professionals.

Staff told us they felt supported by management and worked well as a team

Sussex House Care Home

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 15 March 2018 and was unannounced. The team consisted of two adult social care inspectors and an expert by experience, whose area of expertise was mental health. An expert by experiences is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications submitted, as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with local authority safeguarding team and contracts and commissioning teams.

During the inspection, we spoke with eight people who used the service, four relatives and two healthcare professionals. We spoke with the provider, the registered manager, a senior carer and two care staff and the deputy manager. Following the inspection, we received information from two health professionals.

We looked at three care files, which belonged to people who used the service. We also looked at other important documentation such as medication administration records (MARs) for eight people. We looked at how the service used the Mental Capacity Act 2005. This was to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included three staff recruitment files, training records, the staff rota and minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We also completed a tour of the environment with the provider.

Good

Is the service safe?

Our findings

People who used the service told us they knew who to speak to should they need to raise a concern. They told us they felt safe and trusted staff who helped them with the care and support they needed. Comments included, "I feel safe and looked after really well", "This is my home and I feel safe" and "I'm happy. I've got a nice room with a TV. I feel safe." Another person commented, "If I use my buzzer, a carer comes quickly." Relatives told us, "I am very pleased with the home and know [relative] is always safe" and "I know they are safe here."

The registered manager and staff had a clear understanding of the different types of abuse, how to recognise these and what to do should they witness any poor practice. There were comprehensive safeguarding and whistleblowing policies in place. Staff received the training they needed to understand safeguarding processes. Records confirmed the registered manager had notified the local authority of safeguarding incidents.

Staff had completed training in infection prevention and control. There was personal, protective equipment for staff to use such as gloves, aprons, hand gel, liquid soap and paper towels.

Accidents and incidents were recorded so that learning could take place. Incidents were discussed at team meetings with staff to help prevent reoccurrences.

Medicines were managed safely and people received them as prescribed. There was guidance for staff when people were prescribed medicines on an 'as and when required' (PRN) basis. Records showed people only received PRN medicines when they were actually required. Staff administered medicines to people in a patient and safe way. Records of stocks of medicines received into the service were maintained and any medicines returned were signed for by the receiving pharmacy. Temperatures of the medicine room and fridge were also maintained.

There were sufficient staff employed to meet people's needs. Ancillary staff were in place for domestic, catering and maintenance tasks, which enabled care staff to focus on their caring and support role. The registered manager had access to external maintenance personnel and could request their assistance when needed. Staff we spoke with felt there was adequate staff available within the service. The registered manager regularly reviewed staffing levels to ensure there was adequate staffing available within the service to meet people's individual needs. People we spoke with told us staff were always available when they needed them.

Suitable checks had been completed before prospective staff were employed. Recruitment files included application forms, interview questions and responses, references and Disclosure and Barring Services (DBS) checks. The DBS complete background checks, which enable organisations to make safer recruitment decisions.

The provider had a business continuity plan for specific issues such as flooding or the failure of utilities. The

plan included emergency numbers for staff. Equipment used in the service such as portable electric appliances, fire-fighting items and emergency lighting were serviced regularly. The registered manager checked the emergency call system and held fire drills to make sure staff were aware of what actions to take in emergency situations. All people who used the service had a personal plan which identified the specific assistance they would need from staff should emergency evacuation of the building be required.

A programme of on-going maintenance was carried out by two maintenance people employed by the service. They carried out minor repairs, redecoration, gardening and maintenance checks, for example legionella water temperatures

Good

Is the service effective?

Our findings

People told us, they were able to make their own decisions in their day to day lives. Comments included, "I choose when I get up and go to bed. I can go out on my own, but I do like company. I have choices and have my independence."

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 MCA 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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made six applications to the local authority for DoLS. One DoLS application had been authorised and the remaining five applications were awaiting assessment. This showed us the registered manager was aware of the criteria for DoLS and had acted appropriately.

Staff had completed MCA/DoLS training and were aware of their legal responsibilities. Mental capacity assessments and best interest decision forms had been completed for specific issues. Staff had an understanding of MCA and DoLS and confirmed they had been on the training. They knew how to apply the MCA and if decisions were to be made in best interests, then they had to be the least restrictive option.

Staff had a good understanding of the need to obtain consent before providing care. One member of staff told us, "A lot of the people here have capacity and are able to make their own decisions. We always ask and explain what we are going to do and people are willing to accept support."

People's health care needs were met and they had access to a range of community health care professionals when required. Referrals to the health care professionals were made in a timely way and staff recorded and followed advice and instructions from them. A relative confirmed this and said, "They get the doctor or community nurses if there are any problems." Healthcare professionals visited the service on a daily basis and told us they had a good working relationship with the service.

People were offered choices for their meals, snacks and drinks. Drinks were available in the communal areas and people who used the service were offered drinks and snacks throughout the day. Everyone we spoke with gave positive feedback about the food and said they could join in with the mealtime experience, or take their meal in a quieter area if they preferred to do this. One person told us, "The food here is good, there is plenty of choice. It's chilli today, which I don't like so they are doing a jacket potato with salad." A visiting relative told us, "My relative's food is amazing. They have choice."

The registered manager told us, "There are plenty of choices available for people and the cook meets with everyone to discuss what they would like to have on the menus and menus are planned around this." People who used the service confirmed they were involved in menu planning and asked about their preferences for eating and drinking.

We observed the meal-time experience and saw staff were attentive and served people quickly which meant the meals were hot. People were able to choose where to eat their meal and some people chose to eat in their room. The majority of people who used the service ate all of their meal and all were asked if they would like additional food. This meant larger and smaller appetites were catered for. People were offered another meal if they turned down their original choice. The food looked appetising and healthy. The service had a food hygiene rating scheme (FHRS) score of five, which was the highest score possible. The FHRS shows people the standard of food hygiene in the service.

The staff training records showed they had received training considered mandatory by the provider. This included fire safety, first aid, health and safety, infection prevention and control, safeguarding, mental health, moving and handling, epilepsy, equality and diversity, medication, MCA/DoLS and challenging behaviour. There were various other courses that specific staff had completed such as dementia care, end of life, nutrition and person-centred practice.

Most staff had completed nationally recognised training in health and social care at various levels. The registered manager had completed a management course. Staff told us they received sufficient training to enable them to feel confident when supporting people. A new member of staff described an induction process which included shadowing more experienced staff until they were confident to support people alone. They confirmed they were allowed time to read care plans and policies and procedures, and they had a mentor to provide guidance and advice.

Relatives of people who used the service told us staff were skilled in supporting their family members. Comments included, "The staff here care for my relatives needs really well. The staff are very understanding. The fact my relative is so very comfortable here, is a testimony to the staff."

Records showed staff received supervision and annual appraisal. Staff confirmed this and described a supportive environment. Records showed their practice was observed and feedback given to them to enable leaning to take place. Comments included, "[Name of registered manager] is hot on training, I have recently done epilepsy, dignity, Mental Health, the Mental Capacity Act and Deprivation of Liberty." Another commented, "I have been fully supported since I started; all the team are really good."

The layout of the environment was suitable for people's needs. Corridors were wide and lounges were large enough to support people who may use wheelchairs to move around the service. There were grab rails, shower chairs and hoists available to assist access.

Good

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the staff team. Comments included, "The staff are all a friendly lot. They are very good", "I can dress and undress myself. They are there to help if needed" and "I have choices and have my independence. I feel respected. The management and staff integrate with us." Another person told us, "The staff encourage me to be independent. They help me so much. I feel respected and cared for and I would not change anything about the home." A relative told us, "The staff are very understanding and the standard of care seems very good." Relatives told us visiting times were not restricted.

Staff were clear about how they maintained people's privacy and dignity and promoted their independence. Comments included, "We keep people covered during personal care and doors closed. We always knock on doors" and "You have to be respectful, knock on doors and ask if we can come in." Staff protected people's privacy and dignity. For example, personal care was provided in bathrooms or people's bedrooms behind closed doors. People were supported to maintain their personal appearance to ensure their self-esteem. They looked well cared for, clean and tidy and were dressed with consideration for their individuality.

Seven staff had recently attended dignity training and used an area in the activity room to display information on dignity and to encourage people who used the service to make suggestions on stickers about how dignity and inclusion could be promoted. Satisfaction records were also displayed in this area, that showed people were happy with the care they received.

Staff took their time and used eye contact and gentle, appropriate touch to reassure people. During the inspection one person became anxious. Staff responded in a timely way and used a calming tone to establish the cause of their anxiety and offer reassurance and support. We observed positive interactions with people who used the service and staff spoke about people in a warm, kind, caring and compassionate way. When we asked people who used the service if staff were caring, one person said, "Last year I had a serious health condition. The praise goes to the management and staff in recognising it. I could have died without their care."

Information was provided about the service to help people on admission and during their stay; this was shared with relatives. Residents meetings were held regularly to gain people's, views and information about advocacy was provided. The registered manager told us independent advocates were used to support people in decision-making, reviews and best interests meetings. They said, "Most people here have an advocate, as not many people have families to support them."

People were actively encouraged to make day-to-day choices and where appropriate, people's independence was promoted and encouraged according to their abilities. For example, several people over the lunchtime period were supported to maintain their independence to eat their meal at their own pace without being rushed in any way.

Staff received equality and diversity training, so were aware of the nine protected characteristics of the

Equality Act 2010 namely; age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership. People told us they felt treated as equals and involved by staff.

Staff were aware of the need for confidentiality and held meetings or telephone conversations with relatives or health and social care professionals in private. Personal records were stored securely and computers were password protected.

Requires Improvement

Is the service responsive?

Our findings

During a tour of the building, we found a box of disposable gloves in one person's bedroom. There was no risk assessment in place, to assess whether storing gloves in this way posed any threat to the person. We spoke with the registered manager and provider who removed the gloves immediately and told us they would look at purchasing more secure storage for gloves.

We also observed a bottle of cleaning fluid left unattended on the kitchen hatch.The registered manager and provider explained that the majority of people were involved at some level with domestic tasks to promote their independence skills without any risk. They assured us they would review risk assessments to include the use of cleaning products and equipment.

Although staff were clear about people's individual needs and potential risks, records were inconsistent. Each person had individual risk assessments in place, but not all contained detailed information for staff on the level of support required. For example, one person's support plan advised staff to check the water temperature of the bath before use, but gave no detail of what temperature was acceptable.

Where people required support from staff in managing aspects of their behaviour, care plans did not provide clear guidance to staff on what they could do to support the person to reduce their anxiety levels. For example, one person's care plan detailed, 'Staff to offer advice on how to stay calm and the consequences of their actions.'

When we asked staff about behaviour management they told us people who used the service were not challenging and restraint was never used. They explained a small minority of people may become agitated occasionally and described how they managed these incidents.

We recommend the provider follows good practice guidance in relation to risk assessment and care planning to help mitigate risks.

Later during the inspection we saw one person become agitated, staff responded to them immediately, offering them reassurance and establishing with them the cause of their anxiety. When we spoke to the registered manager about this, they told us they were in the process of changing care plans and this would address the inconsistencies found.

People told us staff were responsive to their needs and offered them choices. Records showed people had an assessment of their needs and input from health and social care professionals before their admission to the service. Risk assessments were completed and the documents used to help develop plans of care. We found some risk assessments were generic and were completed for everyone whether or not the risk applied to them as individuals.

There were inconsistencies in the quality of care plans and risk management plans. Some were very detailed, for example people's preferences for care, their likes dislikes and preferences for activities. Others

contained less information for example, in one person's care plan there was a mental health diagnosis, but no further information for staff to follow to identify when the person's mental health may be deteriorating or how they wished to be supported during these episodes. In another person's care plan, information documented they mobilised around the service with a walking aid. The care plan also detailed the person went out independently, but no reference was made to how they mobilised outside of the service and if their walking aid was suitable for this purpose.

Staff identified people's support needs, but did not always clearly document how the needs were to be met taking into account people's preferences. We saw issues had been highlighted in evaluations or reviews of the care plans and information was recorded in professional visitor's logs, for example, from dieticians. However, the information had not always been updated into the actual plan. This meant staff would have to read through all the evaluations to obtain the most up-to-date information. The registered manager told us they were in the process of reassessing the care plans as they had recognised the inconsistencies.

We recommend information in care files is reviewed and the system of planning care updated to ensure all the care plans record how staff are to deliver care and support people in line with their preferences.

We saw some personal preferences identified in profiles. This information told staff what was important to the person and especially preferences for particular foods at certain times of the day. Despite the disjointed information in care files, we observed staff knew the people who used the service very well. They were able to describe people's needs and how they provided support. The care described by staff and observed in practice was individualised.

Relatives confirmed staff responded well to their family member's needs. They said, "The staff understand how shy [name] is, but they always try to encourage them to engage with activities so they don't feel isolated even though they like to stay in their room."

The registered manager told us people were able to remain at the service for end of life care as it was their home. Staff had completed end of life training and there was a policy and procedure to guide them. They told us health care professionals would be involved when required. The provider told us that a memory garden had been planned within the garden refurbishment for one person who had recently died. The registered manager told us, "When anyone is at their end of life, I like to remind staff that I am available whenever they need me. I want to ensure that we are giving them the best support possible, whether this is putting their favourite radio programme on or reading to them and they have someone with them at all times. I also want people using the service and staff that I am available to support them in any way that I can as I recognise this can be a very a difficult time."

People had daily plans regarding meaningful activities and accessed local community facilities. These included participating in a fun run in Lincoln, trips out, bowling, meals out and, visiting entertainers. Some people planned their own activities within the local community and participated in these independently. We saw people also went out to local shops, clubs, cafes and markets.

The provider had a complaints policy and procedure. There were no formal complaints recorded. An easy read version of the complaints procedure and the complaints folder required updated information. We discussed with the registered manager how the process could be made more accessible to people who used the service. Staff had access to policies and procedures on line and the registered manager told us the complaints folder was rarely used. They also confirmed they would locate an easy read version of the complaints procedure and ensure this was made accessible to people who may require this version.

Relatives told us they felt confident in raising complaints. Comments included, "I don't have any complaints but if I did, I'd go to [registered manager's name]" and "I have never needed to complain about anything. If I had a complaint I would go to the manager." Another told us, "We were unhappy with the content of our family member's care plan. The registered manager did reword it to our satisfaction so we were able to sign."

Other relatives told us they had recently raised concerns about their family member. This had been addressed by the registered manager and the relatives told us things had vastly improved, but they felt things were starting to slip again." When we asked if they had shared their concerns with staff or the registered manager, they told us they had not. When we shared this information with the registered manager they spoke with the relatives and went through their concerns with them and requested they inform them of any further concerns immediately, so they could be immediately addressed.

Requires Improvement

Is the service well-led?

Our findings

There was a quality assurance system, which consisted of audits, checks, surveys and meetings. Action plans were produced when issues had been identified. We found improvements needed to be made to the quality assurance systems, as the current system had not identified the shortfalls in risk assessments and care plan records. The provider's report for October 2017 identified that 'care plans were up-to-date to meet the needs of residents.' It identified new care plans were being rolled out and staff had been positive about the new care plans. It also detailed that all care plans would be transferred over to the new system as reviews were held. A further audit in January 2018 identified care plans were due for review in February 2018, however inconsistencies in care plans found during our inspection had still not been updated following the review. At the time of our inspection, inconsistencies in risk assessments and care plans still needed to be addressed. The registered manager assured us work would be undertaken to address shortfalls in care planning and risk assessments.

Repositioning charts for two people detailed their position should be changed every two hours. Records maintained did not demonstrate that this guidance was being implemented. For example, records for 13 February 2018 showed one person was repositioned at 10.20am and then again at 5pm. Further records for 16 February 2018, identified the person was repositioned at 6pm and then at 10pm. Records for 18 February 2018 showed the same person was repositioned at 3.10 pm and not repositioned again until 9.30 pm. There was no recorded information to explain why the person had not been supported to reposition, for example, if they had been out during this period of time. Neither person had experienced any deterioration in their skin integrity during this time.

We found audits and checks completed had not been fully effective in identifying the gaps in people's postural change records.

We recommend that the service seek advice and guidance from a reputable source, about improving the audits and checks in place to enable shortfalls and inconsistencies to be identified and addressed in a timely way.

The provider visited the service regularly and completed a quality assurance audit. This involved meeting with visitors, people who used the service and staff to obtain their views and experience of the service. They completed a tour of the building and a meeting with the registered manager to review actions from the previous visit and sample records and audits completed.

The provider prepared an action plan following their visit identifying an on-going plan of refurbishment, deep cleaning of rooms and the purchase of replacement furnishings. There were no specific timescales recorded for the completion of this work, but a start date of 29 January 2018. During the inspection, we saw the maintenance person decorating unoccupied bedrooms and the refurbishment work had begun.

We looked at arrangements in place for managing accidents and incidents and preventing the risk of re-occurrence. An audit was completed on a monthly basis, but this focussed solely on the number of

accidents/incidents. We asked the registered manager if they analysed this information and maintained records of the actions taken following their review so that learning could take place. They confirmed records were not kept to this level of detail, although appropriate actions were taken. During discussion with staff they confirmed accidents and incidents were discussed with them so learning could take place.

Staff and people who used the service confirmed they were consulted about the day to day running of the service and attended residents meetings and staff meetings. Staff were positive about the registered manager and the team they worked with. One staff member told us, "I just love it, it's the best job I have ever done." Others commented, "The manager and deputy manager are always happy to help us with care tasks. They are both very good and approachable." People told us the service was well-led and they could share their views with the registered manager and provider.

One person using the service had fed back during a residents meeting their satisfaction of the service. They were reported commenting, 'I would just like to say people who judge and don't listen need to realise what you and your staff do, you have turned this place around for the better and I love it here."

Relatives knew the names of both the registered manager and deputy manager. This showed us they had been in contact with them or made themselves known to them during visits. Professionals we spoke with told us they had a good relationship with management and staff and found the home very accommodating.

Services that provide health and social care to people are, as part of their registration, required to inform the CQC of accidents, incidents and other notifiable events that occur. The registered manager was aware of their responsibilities in notifying agencies of incidents which affected the safety and welfare of people who used the service. The CQC had received notifications of incidents in a timely way.

The registered manager had an 'open door' policy so people who used the service, their relatives, visitors and staff could speak with them at any time. The registered manager was supported by the provider who visited regularly.