Gateshead Council

Gateshead Council Supported Living Domiciliary Care Service

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection carried out over three days on 2 and 10 June and 4 July 2016.

We last inspected Gateshead Council Domiciliary Supported Living Service Newcastle in September 2014. At that inspection we found the service was meeting all of the legal requirements in force at the time.

Gateshead Council Supported Living Service is registered to provide personal care to adults with learning disabilities in the Gateshead area. People are supported by staff to live in small groups, referred to as independent supported living schemes. Different levels of support are provided over the 24 hour period dependent upon people's requirements. People are tenants of their home and pay rent for their accommodation which is leased from housing associations.

The service did not have a registered manager. A manager was in place who was in the process of registering with the Care Quality Commission. 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.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received. Some people could tell us they felt safe. People appeared contented and relaxed with the staff who supported them.

A residential model of care was operating rather than independent supported living. An office had been created in tenants' own homes for the use of staff and the running of the business.

Staff knew the people they were supporting well and there were enough staff on duty to provide individual care to people. Care was provided with patience and kindness and people's privacy and dignity were respected. People were supported to become more independent and maintain some control in their lives, whatever their level of need. Care plans detailed how people wished to be supported and people were involved in making decisions about their care. Records gave detailed instructions to staff about helping people to learn new skills and become more independent.

People received their medicines in a safe and timely way. People who were able, were supported to manage their own medicines. People who used the service had food and drink to meet their needs. Some people were assisted by staff to plan their menu, shop for the ingredients and cook their own food. Other people

received meals that had been cooked by staff.

People were given information in a format that helped them to understand and encourage their involvement in every day decision making. A complaints procedure was available with information provided in a way to help people understand if they did not read.

People were supported to be part of the local community. They were provided with a range of opportunities to follow their interests and hobbies and were encouraged to try new activities. They were supported to holiday in this country or abroad and enjoyed outings to the town, coast and countryside.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions for themselves. There were other opportunities for staff to receive training to meet people's care needs.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

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.

Systems were in place to ensure people's safety and well-being at all times. People were supported to manage and receive their medicines in a safe way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

People were supported to take acceptable risks to help promote their independence such as to travel independently, to learn to make a meal and to manage their medicines.

There were enough staff employed to provide a supportive and reliable service to each person. They were appropriately checked before they started employment.

Staff had guidelines to safely manage and provide consistent care to people who displayed distressed behaviour.

Is the service effective?

Good

The service was effective.

Staff had a good understanding and knowledge of people's care and support needs.

People's rights were protected because there was evidence of best interest decision making when decisions were made on behalf of people. This occurred when people were unable to give their consent to their care and treatment.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

People received appropriate health and social care as other professionals were involved to assist staff to make sure people's

care and treatment needs were met.

Is the service caring?

Good

The service was caring.

We observed and some people could tell us that the staff team were caring and patient as they provided care and support.

A range of information and support was provided to help people be involved in daily decision making about their care and support needs.

People's rights to privacy and dignity were respected and staff were patient and interacted well with people.

People were supported to maintain contact with their friends and relatives.

Staff supported people to access an advocate if the person had no family involvement. Advocates can represent the views and wishes for people who are not able express their wishes.

Is the service responsive?

Good

The service was responsive.

People received support in the way they wanted and needed because staff had detailed guidance about how to deliver people's care.

People were supported to live a fulfilled life, to contribute and be part of the local community. They were encouraged to take part in new activities and widen their hobbies and interests.

People told us they knew how to complain if they needed to. They had a copy of the complaints procedure that was designed in a way to help them understand if they did not read.

Is the service well-led?

Requires Improvement

The service was well-led in most areas.

A limiter is put in place that restricts the domain being rated as good until the manager of the service is registered with the Care Quality Commission. The manager was in the process of applying for registration.

We have made a recommendation as the service operated a residential model of care rather than an independent supported living model that respected the rights of tenants living in their own homes.

A management team was in place who promoted the rights of people to live a fulfilled life within the community.

An ethos of individual care and involvement was encouraged amongst staff with people who used the service.

The provider monitored the quality of the service provided and introduced improvements to ensure that people received safe care that met their needs.

Gateshead Council Supported Living Domiciliary Care Service

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.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authority who contracted people's care and spoke with the local safeguarding team.

This inspection took place on 2 June, 10 June and 4 July 2016 and was an unannounced inspection. It was carried out by an inspector and an expert-by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for people with a learning disability. During the inspection the inspector visited the provider's head office to look at records and speak with staff. After the inspection the inspector visited some people who used the service to speak with them and the staff who supported them. An expert-by-experience carried out telephone interviews with some relatives of people who used the service.

As part of the inspection we spoke with five people who were supported by Gateshead Council Supported Living Service, one service manager, one manager, three senior support workers, two support workers and

nine relatives. We reviewed a range of records about people's care and checked to see how the schemes were managed. We looked at care plans for four people, the recruitment, training and induction records for five staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and the quality assurance audits that the manager completed.

Good

Is the service safe?

Our findings

People who used the service said they felt safe. One person commented, "Yes, I do feel safe living here." Relative's also confirmed people were safe. Their comments included, "There has never been anything happen that has caused me concern or worry," and, "I have peace of mind that [Name] is well supported."

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the manager. They were aware of the provider's whistle blowing procedure (reporting bad practice) and knew how to report any worries they had. They told us they currently had no concerns and would have no problem raising concerns if they had any in the future. Records showed and staff confirmed they had completed safeguarding adults training. They were able to tell us about different types of abuse, were aware of potential warning signs and described when a safe guarding incident needed to be reported.

The provider had a system in place to log and investigate safeguarding concerns. No safeguarding alerts had needed to be raised by the service. The manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of any allegations of abuse.

Staff were aware of the reporting process for any accidents or incidents that occurred. These were reported directly to the senior worker of the house so that appropriate action could be taken. We were told all incidents were audited in each house and at head office to check action was taken as required to help protect people. The manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. These assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments. These were also in place to help maximise people's independence and to encourage positive risk taking and at the same time keep people safe. They included for example, travelling independently, managing medicines, budgeting and cookery and kitchen skills. Each assessment had clear instructions for staff to follow to ensure that people remained safe. Our discussions with staff confirmed that guidance had been followed.

Some people who used the service told us they did checks around the house supported by staff for health and safety and fire safety. This was to make them aware of safe procedures and to help keep them safe.

Positive behaviour support plans were in place for people who displayed distressed behaviour and they were regularly updated to ensure they provided accurate information. The care plans contained detailed information to show staff what might trigger the distressed behaviour and what staff could do to support the person. They provided guidance for staff to give consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed and challenging. Where incidents had occurred, we saw that the staff had received advice from external healthcare professionals, such as the

behavioural team and psychologist. This provided staff with specialist support to help some people manage their behaviour, which had resulted in fewer incidents happening.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased or decreased as required. As the service supported people to learn new skills and to become more independent in activities of daily living a person may, over time, require less staff support.

Staff we spoke with and records confirmed that staff had been recruited robustly. The necessary checks to ensure people's safety had been carried out before people began work in the service. We saw relevant references had been obtained before staff were employed. A result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had also been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. The provider information return (PIR) stated tenants were involved in the recruitment process. This included being part of the panel interviewing the candidate, holding their own interviews, having family/advocates as part of the interview process, or meeting the candidate for a chat and giving their views.

We checked the management of medicines. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines. Suitable checks and support were in place to ensure the safety of people who managed their own medicines. Care plans detailed the guidance required from staff to help people safely manage and be responsible for their own medicines. One person told us, "Staff are helping me so I can manage my own medicines."

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included, "We get plenty of training," "We have lots of opportunities for training," "The training matrix flags up when refresher training is due," "I've done training about Mental Capacity," and, "We do some training face to face and also e-learning."

Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff for a number of days. This ensured they had the basic knowledge needed to begin work. Several staff told us they had worked at the services for many years. They said initial training consisted of a mixture of face to face and practical training. The manager told us new staff would complete an induction and study for the Care Certificate in health and social care as part of their induction training.

The staff training records showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as autism awareness, healthier eating, communication, dignity, physical intervention and boundaries, mental health awareness, distressed behaviour, mental capacity and equality and diversity. The PIR stated 100% of support staff had achieved a National Vocational Qualification (NVQ) at level 2, now known as the diploma in social care and approximately 65% of the staff team had achieved an NVQ at level 3. Managers received management training to help develop their skills managing people and other aspects of management.

Staff told us they received regular supervision from the management team, to discuss their work performance and training needs. They said they were well supported to carry out their caring role. Staff members comments included, "I receive about six supervisions a year," "The manager does my supervision," and, "I'm asked how things are going at work." Staff said they could approach the management team at any time to discuss any issues. They also said they received an annual appraisal to review their work performance. This was important to ensure staff were supported to deliver care safely and to an appropriate standard.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. Within the Independent Supported Living (ISL) houses some people did require constant support to keep them safe. The manager was aware the deprivation of liberty process was not applicable within the supported living environment as people were tenants in their own house therefore advice was taken from the local authority about the Court of Protection processes. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity. We were told there was one person where this process had taken place and a court authorisation was in place to keep them safe.

People who used the service were involved in developing their care and support plan and identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. The PIR showed that there were plans to make better use of capacity assessments where there were concerns regarding a person's ability to make a decision.

We checked how the service met people's nutritional needs and found that people had food and drink to meet their needs. The manager told us they were on a malnutrition task force with some other agencies to develop a standardised nutritional training programme. This training was to be delivered to staff across some sectors of the organisation to ensure people who required support were well nourished. People received support in activities of daily living such as cooking. They required different levels of support. For example, we saw a staff member assisted a person to make drinks. Some people we spoke with said they were supported to make their own meals. They were helped by staff to plan their menu, shop for their food and were supported to cook their own meals. People commented, "I choose my own meals and go shopping for the food," "I like curry and pasta," "I'm making my meal tonight," and, "I help cook my food."

People's care records included nutrition care plans and these identified requirements such as the need for a weight reducing or modified diet. Risk assessments were in place to identify if the individual was at risk of choking or malnutrition. We noted that the appropriate action was taken if any concerns were highlighted.

People who used the service were supported by staff to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. For example, in people's care records there was evidence of input from GPs, opticians, dentists, speech and language therapists, behavioural team, nurses and other personnel. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. Written guidance was available for staff with regard to people's support requirements.

Good

Is the service caring?

Our findings

Not all people we visited could comment verbally about the support they received from staff. We saw they appeared comfortable and relaxed with staff. During our visits there was a calm and pleasant atmosphere in the houses. Staff interacted well with people. People who used the service and relatives were complimentary about the care and support provided to people. Peoples' comments included, "I like living here," "The staff are great," "The staff are brilliant," and, "I'm learning to do things for myself." Relative's comments included, "The staff are really good," "The service is absolutely brilliant," and, "It's brilliant there, they are a little family and [Name] is very happy," and, "It gives me peace of mind knowing[Name] is supported and loved."

People who used the service were supported by staff who were kind, caring and respectful. During our visits we saw staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. This guidance was also available in people's support plans which documented how people liked and needed their support from staff. For example, one support plan stated, "I like opening my mail. I would like staff to support me and help me to understand what it says and what I need to do to reply." All people's records advised staff how to communicate with the person. Examples in support plans included, "I can verbally communicate. Sometimes I choose not to, I will tell you if I am happy and sometimes my facial expressions will let you know that I have a pain or I'm unhappy," and, "Although I have limited verbal communication, I like to tell you what I would like or need."

People were encouraged to make choices about their day to day lives. One person told us, "I can go to bed when I want." Another person said, "I can choose where to go on holiday." Not all of the people were able to fully express their views verbally and staff used pictures and signs to help the person to make choices and express their views. We saw pictures were available to help the person make a choice with regard to activities, outings and food. People's individual support plans with regard to decision making included details such as, "I use pictures to communicate my wishes if I can't make myself understood," "I can make decisions on my own, however I need information to make my decisions," and, "I need support to make choices, what I want to do and where I want to go."

People and relatives told us they were involved and kept informed of any changes within the organisation and staff kept them up to date with any changes in people's care and support. We saw information was made available in a way to promote the involvement of the person. For example, people had been involved and made aware of possible changes in the provision of day care and residential service provision within the organisation. Information was made accessible to people by use of pictures, symbols and computer discs if people did not read or use verbal communication. We saw evidence of this with the complaints procedure, assessments and care records.

People told us they were involved and they said they were listened to. They were involved in regular individual meetings to discuss their care and support needs which also included discussion about their plans for the future and their aspirations. Monthly meetings were held in each of the houses to discuss the

running of the household and ask people for any suggestions or areas for improvement.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. People were able to choose their clothing and staff assisted people, where necessary, to make sure that clothing promoted people's dignity. Support plans advised staff of support people may need.

The manager told us people who did not have relatives to provide advice and support to them would be supported by an advocate. Advocates can represent the views for people who are not able to express their wishes. An advocate would become involved where a person needed to have additional support whilst making decisions about their care. The manager gave an example of when advocates had become involved due to changes in day service provision for two people.

Good

Is the service responsive?

Our findings

People were supported to access the community and try out new activities as well as continue with previous interests. Records showed they were supported with a range of activities and these included theatre trips, going to discos, walking, cycling, athletics, football, javelin, swimming, cinema visits, trips to the country and coast and meals out. Some people proudly showed us medals they had won at Special Olympics sessions, (these had started after the 2012 World Olympics) and were held at the local athletics stadium. People were supported by staff to go on holiday or for days out either individually or in a small group. Peoples' comments included, "I've been to see Dirty Dancing in London, and I want to go to London again to see a show," "I went to see Tom Jones at the theatre," "I enjoy using my X box (computer console)," "I like shopping," and "I do pottery." Some people attended day services or college and some people were in paid or voluntary work.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. We were told a long process took place to check that people wanted to live at the house and that they were compatible with people who already lived there. The phased introduction included visits such as tea time and overnight visits and these were carried out at the pace of the person.

Records showed pre-admission information had been provided by relatives and people who were to use the service. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Support plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, mobility and communication needs. Support plans provided instructions to staff to help people learn new skills and become more independent in aspects of daily living whatever their need. For example, a person's financial support plan stated, "Staff to support me when I go to the Council Offices to collect my money and for signing for my money." People we spoke with told us, "I go to Asda to do my shopping," "Staff help me with cooking," and, "I pay my own bills." One local shop keeper had commented to staff, "I am very impressed with the way your team supports tenants to achieve their independence. I have been watching the team give [Name] encouragement every week. They are able to cross the road themselves using the zebra crossing and they can come to the hairdressers on their own."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, records included, "If I get anxious I will shout," and, "Once I have showered I will go to my bedroom and choose my clothing for the day." Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. A relative told us, "It's a good service modelled around people's care needs. They [Staff] pace the service to suit the person so that they don't get worried or stressed about what is happening. It works really well for [Name]."

Staff at the service responded to people's changing needs and arranged care in line with people's current

needs and choices. Records showed regular meetings took place with people. Weekly meetings took place to discuss menus and activities for the following week and monthly meetings were held to review people's care and support needs and aspirations for the following month. We saw that staff completed a daily record for each person that documented their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

One relative we spoke with said they were involved in discussions about their relative's care and support needs. They commented, "Yes, I have paperwork here so I know that [Name]'s care is reviewed and I think they have an excellent care package." Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. One relative told us, "They bring [Name] to see me because I can't use the bus anymore." Most people had visitors and some people went to spend time at their family homes.

People had a copy of the complaints procedure which was written in a way to help them understand if they did not read. One person commented, "I'd talk to staff if I was worried." A relative told us, "I've no concerns regarding the service itself or the staff." A record of complaints was maintained and we saw two 'grumbles' (minor concerns) had been received and they had been resolved within the service and passed to the quality assurance department of the organisation. We were told formal complaints were investigated independently by a manager of another service. Regular meetings took place with people who used the service and they were asked if they had any concerns about the support they received.

Requires Improvement

Is the service well-led?

Our findings

The manager was not yet registered with the Care Quality Commission but they were in the process of applying for registration.

We noted that a residential model of care was operating rather than true independent supported living. Although people were tenants in their own houses, and should have the right to do what they wanted with their houses, the organisation was operating their business from each household. Houses were equipped with an office. In one household a separate room was used, in another household the office was the tenant's sitting room which was equipped with a desk and computer for the use of staff. This meant tenants did not have privacy and their house which they paid for was also used for the running of the business.

A large amount of records, not just records to ensure staff had guidance to meet people's needs, were kept at households which should have been kept at the head office. We noted a copy of people's care records were not available at the main office but rather the only copy was available at the person's house. This meant staff at the main office did not have access to people's care records to manage the regulated activity and to co-ordinate and arrange peoples' care and support.

We recommend the service considers adopting the supported living model of care rather than a residential model of care in order to respect tenant's rights and their homes.

The culture of the service promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may have wanted, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the houses we visited was open and friendly. Staff said they felt well-supported by senior staff in the households and by staff from head office. Comments included, "I can always speak to a manager," "I've worked for the organisation for years," and, "We're a staff team."

Staff commented they thought communication was good and they were kept informed. They told us they received a shift handover from the person in charge to make them aware of any changes and urgent matters for attention with regard to people's care and support needs. A communication diary was also used to pass on information and record any actions that needed to be taken by staff. Staff told us and meeting minutes showed staff meetings took place regularly. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Minutes showed staff had discussed service issues, health and safety, training, complaints, the needs of people who used the service and feedback from people from head office who monitored the quality of care provision. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who used the service. The audits consisted of a range of monthly, quarterly and annual checks. They

included finances, the environment, medicines and care documentation. A comprehensive three monthly peer audit was carried out by a manager from another service that was aligned to the CQC Key Lines of Enquiry (KLOE) evidence gathering as well as talking to staff and people who used the service. We saw audits identified actions that needed to be taken. Audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to staff and people who used the service. The PIR showed it was planned to extend the survey to include families to comment on the quality of the service provided. We saw the results of the 2015 survey for November. People were supported by a volunteer who was independent of the organisation so they could complete the questionnaire openly. 13 responses were received from the 13 questionnaires given out. Nine people commented the service was very good and four people responded the service was good. Very good being the highest comparator. Peoples' comments included, "I like my home, its' the best place to live," "I've got a nice garden and my new furniture," "I'm happy here," "I've just returned from Benidorm," and, "I do my shopping with a member of staff."