St Elizabeth's Centre

St Elizabeth's Domiciliary Care Agency

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
St Elizabeth's Domiciliary Care is a supported living service for people with learning disability and autism. The service was provided to adults in shared accommodation on their college site and in individual flats.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection 30 people were supported with the regulated activity.

People's experience of using this service and what we found
The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture
Right support
People had care plans and risk assessments that in places had contradictions or missing information to identify risks people faced and how staff should manage these. Staff were not always knowledgeable about the content of these risk assessments.

Due to staffing restrictions there were times where people could not have a fulfilling and meaningful everyday life. People were not always supported to pursue their interests, although there had been more opportunity than at the last inspection., People told us they were not able to go out with in the local community as much as they wished to.

The provider failed to ensure people were supported with their medicines in line with safe and best practice to achieve the best possible health outcomes. We found the same areas requiring improvement that were identified at the last inspection.

The provider failed to support people to have maximum possible choice, control and independence in terms of their day to day support.

Right Care
The service failed to ensure there were enough appropriately skilled staff to meet people's needs and keep them safe.

People were not always supported by a service that had effective systems in place to report and respond to accidents and incidents. Accidents and incidents were identified however, there was a lack of action following these incidents which meant people continued to receive poor care.
Right culture
People were supported by staff who did not always understand best practice in relation to supporting people with a learning disability. The provider did not ensure people were supported by staff that had the right skills and training, however the provider had started to address this.
People's quality of support was not always enhanced by the providers quality assurance system. Areas for improvement were not always documented, and it was unclear if these were acted on. This had an impact on people's care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 08 February 2022). At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 02 March 2022 During this inspection the provider did not demonstrate that adequate improvements had been made. Therefore, the service remains rated as inadequate overall. Therefore, this service is still in Special Measures.

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

We undertook this focused inspection to check they had followed their action plan and to follow up on intelligence we had received about the service. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Elizabeth's Domiciliary Care Agency on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe, not having enough skilled staff which impacted on people's day to day lives, people not receiving support that was person centred and the management oversight did not always identify and implement improvement promptly.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Elizabeth's Domiciliary Care Agency

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team was made up of three inspectors, a member of the CQC medicines team, 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.

Service and service type
This service provides care and support to people living in eight 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post, however the provider was in the process of employing a new manager who would apply to become registered.

Notice of inspection

This inspection was unannounced

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We communicated with 11 people who used the service and 12 relatives about their experience of the care provided. People who used the service who were unable to talk with us, so we used different ways of communicating including using Makaton (a type of sign language), pictures, photos, symbols, objects and their body language.
We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. For this inspection, we used this communication tool with four people to tell us about their experience.

We spoke with 22 members of staff including the nominated individual, managers, training department, human resources and support workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We reviewed a range of records. This included five people's care records and 9 medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly visits the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure they had robust systems to demonstrate safety was effectively managed. This put people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were not always kept safe from avoidable harm because staff were not always confident on what to look out for or recognise where people were put at risk of abuse.
- People's risk assessments were not clear or coordinated with the information stated in the care plans. There were several examples where we saw risks had been identified but records did not adequately demonstrate the support provided to people to mitigate these risks. One example being where someone had been assessed as needing 15-minute checks due to the risk of their epilepsy. Records did not evidence these checks had been completed. This placed people at the risk of harm.
- Staff could recognise signs when people experienced emotional distress. However, they did not always know how to support them to minimise the risk to them and other people to keep them safe. Incidents following the use of restraint did not always follow the correct plans as staff did not always use the correct the correct strategies. This put staff and people at risk.
- There was a lack of shared lessons learnt with the whole team and the wider service. Where safeguarding's and risks emerged, the manager gathered the information relating to accident and incidents, however they did not effectively look at the overall trends and themes. This meant the manager and staff team were not able to learn from these.
- Incident reports around medicine errors showed that certain actions were recommended to be followed to prevent these errors from occurring again. On review we found that these actions had not been followed and the provider lacked oversight to ensure staff were adhering to the recommended actions to prevent further errors.
- Relatives gave mixed views about the safety of their family. One relative said, "Yes, [Relative] is definitely kept safe." Whereas another relative said, "They have one member of staff at night but [relative] is meant to have one to one waking hours and often does not go to sleep until very late so basically does not get it the support they need, making [relative] unsafe."
- Despite this, People we spoke to said they felt safe. One person said, "Yes, I feel safe, I like living at [Bungalow]."

Using medicines safely

● People were not supported to manage their medicines safely. At the last inspection we raised concerns about medicine management. The provider had shown an inability to effectively and in a timely way address the concerns raised at the previous inspection. For example, documents to help staff to administer when required 'PRN' medicines were not in place for all prescribed medicines. When a medicine used for the management of agitation and aggression was administered, we could not be assured that these are being used appropriately as, there were no records of why a PRN medicine had been administered or if it had been effective.

● Records continued to show that people were usually being given their medicines as prescribed. Medicines administration round times were conducted at the same time each day but these did not always meet the requirements of a prescribed medicine. For example, where people were prescribed a medicine to aid with sleep if still awake past a certain time, records indicated that these medicines were regularly being given significantly earlier than the time indicated on the prescription.

● The management team continued to fail to make sure medicines were stored at appropriate temperatures. Staff had failed to escalate this when recording daily temperature monitoring. There were gaps in the temperature recordings in most bungalows.

● The medicines management policy did not reflect the processes taking place at the service and was not fit for purpose. We were told this was in the process of being reviewed but there were no clear procedures in place to tell staff what was expected of them when administering medicines or how to do this safely. For example, where people had handwritten amendments to medicine administration charts these were being completed by nurses not employed by the provider. Instructions on these entries sometimes lacked detail. There were no records to indicate if these followed the prescriber's instructions and often had no authorising signatures or only a single signature.

● At the time of the inspection training records confirmed low numbers of staff who had been assessed as competent to administer medicines. Only 26% of staff were trained to administer emergency intervention medicines and 25% of staff to administer medicines. Staff told us that due to a lack of medicines trained staff they would sometimes be asked to cover multiple bungalows medicine rounds, which is not in keeping with personalised care. This had to errors due to the time pressures they would have to administer medicines for multiple people

● People were not always supported to mitigate risks with their epilepsy. Staff confirmed people did not take their emergency medicines with them when leaving their home to go for walks around the grounds. The staff went on to say at times people were supported to leave the building with staff that were not trained in administering emergency intervention medicines. One staff member said, "For example, this morning the intervention trained meds person went off our bungalow and somebody had a seizure. The deputy was over as soon as possible but it's not ideal." This particular person had intervention medicines and there was not a risk assessment in place to mitigate this risk in the event of a seizure. This put people as significant risk of harm.

The provider had failed to ensure they had robust systems to demonstrate safety was effectively managed. This put people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure that people had the opportunity to have a fulfilling life with dedicated time to develop their independence. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● At the last inspection the provider spoke about their drive to recruit new staff and were open about the staffing difficulties. Since then the provider had focused their efforts on employing new staff, however it was still evident that staffing shortages continued to impact on people's care.
● Records showed that at times there were insufficient staff and in some cases there had been times where staffing levels were critically low which put people at risk. In addition, this meant people had not received their commissioned hours to meet their needs. This was evident through people's daily records where it continued to show limited opportunities for people to do different experiences.
● Staff spoke about additional stresses with working short staffed. For example, the provider had implemented a checking system where people who had high risk of SUDEP. SUDEP is the sudden, unexpected death of someone with epilepsy, who was otherwise healthy. Staff felt this was not always achievable and impacted on people's support. One staff member said, "To be honest the 15-minute checks take away from time we could be spending with people."
●In addition, the lack of staff being medicine trained meant this had a strain on staffing. One staff member said, "Quite often I have to cover the meds across 3 different bungalows. I think this is part of the reason I made the error; I was trying to do too much."
● People said there were times where they could not go out of the bungalow or do things they enjoyed because of the lack of staff. One person said, "I love going out, I was supposed to go out tonight but because of staff I didn't, maybe on Thursday I will be able to." Staff confirmed this, "It can be hard to support people to do what they would like to do each day, especially when we don't have a driver working."

People did not consistently receive their assessed and commissioned staffing hour, which meant they were not able to have the opportunity to have a fulfilling life with dedicated time to develop their independence. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Relatives felt staff were nice. One relative said, "I think the staff are lovely they try hard, but the turnover is high, there is a lot of bank staff." Another relative said, "It is getting better (the staffing issue) they had some that could barely speak English."
● The provider operated a safe recruitment process; appropriate checks were undertaken to help ensure staff were suitable to work at the service. A disclosure and barring service (DBS) check and satisfactory references had been obtained for all staff before they worked with people. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● The provider ensured there was enough personal protective equipment (PPE) for staff to wear in line with the current government guidance. We found staff to be wearing PPE correctly during our inspection. Relatives gave feedback that on the whole they had experiences staff wearing PPE but indicated there were times where they had not seen staff follow current guidance.
● The service supported safe visits for people living in the service in line with current guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.

At our last inspection the provider had failed to support people in a person-centred way that enabled them to have choice and control about the service they received. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● At the last inspection we identified care plans not always clear and coordinated with risk assessments or other health professional guidelines and lacked important information relating to people's support. Although there had been some improvements in the documentation, we continued to find care plans and risk assessments that were not coordinated. This meant staff could not be confident they were providing the right support for people.
● Care and support plans failed to reflect people's aspirations and future goals or focus on people's quality of life outcomes. This was evident when observing staff taking an active role in people's day to day life and not encouraging independence.
● Relatives gave mixed views about how the staff promoted positive outcomes for people and developing their independence. One relative said, "They could do more - I just don't see it – he goes to college then home and then lies on his bed for the rest of the day." Another relative said, "It's been a learning curve, but St Elizabeth's are getting there slowly."
● People we spoke with felt their social needs were not being met. People said they lacked the opportunity to go out as they wanted to, records confirmed this. One person said, "I don't go out. I would like to go out more, I want to go out of the site." Another person said, "I have a friend I would like to see more. I sometimes go over and see them to have a drink."
● People had different forms of communication, we found that not all staff had the skills to support people with their preferred communication. For example, a number of people would use different communication aids, one being signs. Staff were not trained to sign, and we observed staff not attempting to communicate with people in this way.
● During the inspection it was evident that the dynamics of the service user group and people's support needs and interests were very different. When speaking with people they all said they got on well with each other, however, did identify some points that questioned the compatibility of the people living there. Some staff felt people were matched together well, however others didn't. One staff member said, "Not on my

bungalow, they all have different interests." Another staff member said, "At the moment yes, I think people are placed really well together. I know previously there have been some difficult situations and people used to clash once in a while. We had to put a safeguarding plan in place in the end, so they were not left alone. We'd have to separate two people - one at one end of the house and the other at the other end." One person had been moved three times due to the relationships with other people living there.
Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
●People's care records were not always updated in a timely manner when changes were made by healthcare professionals. In addition, dates set for reviewing people's epilepsy medicines were not always being met. This meant that staff might be following guidance that was no longer suitable for the person they were caring for and could put people at risk.
● The service model continued to be, that St Elizabeth's provided services from their in-house therapy team and it was a part of the agreement for people being supported by St Elizabeth's Domiciliary Care Agency. Although, the provider had made effort to involve different professionals from outside of the organisation, it still remained that people did not have full choice and control of who and what services they could use.

The support people received was not person centred and people were not able to have choice and control about the services they received. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, the people felt staff were kind and they felt happy with the support. One person said, "I get on with the staff" and another person said, "The staff will help me."
● People were supported to have enough food and drink and we saw people getting involved in decisions about the food their purchased, however people said they were not always involved in cooking the meals.

Staff support: induction, training, skills and experience
● At the last inspection we identified that people were not always supported by staff who had the relevant training or skills. We continued to find staff had not received all relevant training. For example, it was identified all staff needed to have first aid training following an incident, but only 24% of staff had received this. Only 25% of staff were medicine trained with 26% staff signed off to administer emergency intervention medicine. This put people at risk of not receiving safe care due to staff not being adequately trained.
● Staff confirmed there were times were people were not supported by the right staff at the right time. One staff member said, "On site someone could be supported by a non-intervention trained staff, providing they weren't going far, as there are always people around who are trained." On the day of the inspection this was evident, and we found staff supporting people who were not adequately trained.
● The provider was not ensuring they were adhering to their epilepsy policy in terms of staff training. The policy indicated staff should be trained yearly, however this was not the case and records showed staff had not received up to date training.
●People's care which resulted in them experiencing unnecessary restrictions of their freedom and opportunities due the deficits with staff skills and training.

There were insufficient numbers of suitably trained staff. This placed people at risk of harm. This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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 had the appropriate legal authority and were being met.

● People were not always empowered to make their own decisions about their care and support. For example, we found one person enjoyed using technology, however staff made the decisions as to when they felt the person had spent too much time and would limit this without clear guidance. A staff member described this would be used as part of a reward. This does not promote respect the person's human rights.
● Staff were not always able to explain why there were decisions to restrict people or if this was the least restrictive measure to take. One staff member said, "There are also some locks on cupboards as one man will take all the food. I believe this was done via the right approach and has all been authorised, but I am not sure as I was not involved."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure they had governance systems that were robust which meant the service was not effectively managed. This put people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At the last inspection we found the provider failed to ensure staff understood what good care looked like and promote choice and control when developing people's support network. There continued to be a stipulation that if the person lived in the accommodation the person had to have the support from the provider and use their therapies. This did not demonstrate they fully understand their responsibilities in terms of legal requirements for services registered with the Care Quality Commission.
- The provider had taken steps to educate staff through culture workshops and open discussions, however we found several examples where people were not treated with dignity and respect and were restricted by staff. One staff member described how they would restrict a person's use of technology and would allow them to use this but, "We do this as long as he is being a good lad, if not, we'll say you need to calm down and relax." This continued to show the staff team lacked the understanding of the guidance of right support, right care, right culture.
- Staff used language that was not respectful or age appropriate for example, using language such as "good boy" and being "non-compliant."
- We observed staff interactions to be caring, however we found further improvements needing to be made to instil a culture of care in which staff truly promoted people's individuality, protected their rights and enabled them to develop and flourish.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had shown an inability to effectively and in a timely way address the concerns raised at the previous inspection and did not take the opportunity to learn lessons in order to improve the service For example, medicines management, encouraging people to shape their own support and improve staff training and skills.

● At the last inspection we found the providers systems for monitoring quality were not robust or effective. At this inspection, the provider spoke about a new quality assurance system they were planning on implementing, however this was yet to be introduced, because of this we found the systems were still not effective.
● The management team completed regular audits; however, these were inconsistent between each bungalow in the audits completed and the quality of information captured. Where actions were identified these were not always captured in the service improvement plan. We saw examples where actions were not completed over several months.
● The provider had started to capture lessons learnt and shared these with management. However, we found examples were lessons learnt and actions had been identified but not yet shared with the rest of the staff team. This meant staff were not equipped with the knowledge to change their support practice for the better.
● The provider lacked oversight of certain aspects of the care and care records being completed for people using the service. Records were sometimes being completed by staff not employed by the provider. Also, the provider did not adequately distinguish between the roles and responsibilities of its own staff and those employed by other providers located in various areas of the St Elizabeth's Centre. This did not demonstrate they fully understand their responsibilities in terms of legal requirements for services registered with the Care Quality Commission.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
● The provider had been open and honest about the recent inspection. The provider had offered meetings to discuss this with staff, people living in the service and family members.
● The provider had started to seek feedback from people and those important to them about the development of the service, however these suggestions still needed to be fully acted on and embedded into the service.
● The provider had recently sent out a survey to relatives, people and staff however, we did not see evidence that the findings of this had transferred into an action plan to drive improvements for people.
● Relatives felt that communication between the provider and themselves could improve. One relative said, "They are lovely people, but they just keep changing - we don't know what they are doing, we are struggling so much with them." Although another relative said, "It is well managed, they are definitely improving."

Governance systems were either not in place or robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There had been a number of management changes recently and although staff acknowledged it can be difficult with changes, they felt supported by their current manager. One staff member said, "I get support from my line management. My manager is very approachable and if I have any feedback, I feel I will be listened to and any concerns addressed."

Working in partnership with others
● Following the previous inspection, the provider had engaged with a number of professionals working closely with them to help improve the support of people.