Royal Mencap Society

Royal Mencap Society - Broad Oaks

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?	Good

Summary of findings

Overall summary

Royal Mencap Society - Broadoaks is registered to provide accommodation and personal care for up to 30 people. The home is located in a residential area of the March. When we visited there were 26 people living at the home. The home has individual buildings [houses] where people live in small groups. This comprehensive inspection took place on 7June 2016 and was unannounced.

A registered manager was in post at the time of the inspection and had been registered since 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home. 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 kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. Staff had an awareness of the application of the MCA and people's mental capacity was assessed. DoLS applications had been made to the appropriate authorities and the outcome of their review of the applications was yet to be received.

People were looked after by staff who were trained and supported to do their job to meet people's individual needs.

People were treated by kind and respectful staff who they liked. People and their relatives were provided with opportunities to be involved in the review of people's individual care plans.

People's individual needs were met. People were supported to reduce the risk of social isolation; they were helped to go shopping or take part in recreational activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted upon.

The registered manager was supported by a team of management staff and care staff and staff were supported by a management team. Staff were managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring

procedures were in place and action was taken where improvements were identified.

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 were safely looked after by sufficient numbers of care staff.

Recruitment procedures ensured that only suitable care staff were employed.

People's medicines were managed in a safe way by care staff who were trained and assessed to be competent.

Is the service effective?

Good

The service was effective.

People were looked after by care staff who were trained and supported to do their job.

People's rights were protected as the provider was acting in accordance with the principles of the Mental Capacity Act 2005.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People's rights to privacy, dignity and independence were valued and respected.

Care staff were kind and helpful.

People were enabled to choose how they wanted to be looked after.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met.

People were enabled to take part in activities which were important to them.

The provider responded to people's complaints and this was to the satisfaction of those who had complained.

Is the service well-led?

Good

The service was well-led.

The safety and quality of people's care was monitored and kept under review.

People were enabled to make suggestions and comments about their care.

Care staff were managed to provide people with safe care.

Royal Mencap Society - Broad Oaks

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 7 June 2016 and was unannounced. It was carried out by one 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.

Before the inspection we received information from a local contracts and placement officer to help with the planning of our inspection and to obtain their views. We also looked at all of the information that we had about the home. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Furthermore, before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with10 people who used the service and two relatives. We also spoke with the registered manager; two service managers; the administrator and seven members of care staff.

We looked at three people's care records and records in relation to the management of the service and the management of staff. We observed people's care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

People we spoke with told us that they felt safe and gave their reasons for feeling they way they did. One person said, "I feel safe. I have a 'panic button' I can push and the staff come over to see me. Staff are not cross if I push the 'panic button'." Another person said, "I feel safe here, the staff are nice to me." One relative said, "[Family member] is very safe here, because they are well supported and well looked after."

Members of care staff were aware of their roles and responsibilities in keeping people safe from harm. They were trained and were able to demonstrate the correct reporting procedures in the event of someone being placed at such risk; this included reporting directly to the registered manager or to the local safeguarding authority. Members of care staff also demonstrated their knowledge regarding the physical and psychological signs that people may show if they were experiencing harm. One member of care staff said, "They [person] could become withdrawn or there may be a change in their usual habits." Another member of care staff added, "There could also be unexplained bruising." The registered manager had sent us required notifications when people were placed at the risk of harm; the information detailed in the notifications showed that measures were taken to reduce the likelihood of a similar occurrence. In addition to these measures, the information demonstrated that the registered manager had followed the correct reporting procedures in making the local authority aware of such incidents.

We checked to see if people were looked after by sufficient numbers of staff. One person said, "There are enough staff. They come round." We saw that people were supported by a sufficient number of unhurried staff. Members of care and management staff told us that there was always enough staff to look after people. This included staff providing people with one-to-one support. Two-to-one support was also provided to make people safe when using transport and in line with people's risk assessments. One service manager told us how people's needs were met and said that there was an increase in numbers of staff working shifts to meet people's social needs. They gave an example of this and said, "I roster in extra staff for when people go to the 'Truck Fest'". One member of care staff, who usually worked at night, described the recently introduced on-call system that enabled staff to contact managers during out-of-hours. They said, "We have an on-call system for them [on-call manager] to get people [staff] to cover, so you are never short of staff."

The provider wrote in their PIR that agency staff were used to cover staff vacancies and absences. The registered manager confirmed that there had been agency staff used to complement the staffing numbers. However, during the week of our inspection, they told us that agency staff were not required due to successful recruitment of permanent staff. One service manager supported this and said, "We were using agency staff but from this week there is no longer any usage of agency." One member of care staff expanded on this and said, "There was a high turnover of staff but [name of registered manager] has stabilised the situation. Now we have a low turnover of staff and it is more consistent in how we do things." Another member of care staff said, "There was a point when we were low on staff and we all had to 'pitch' in. But now we've got more staff. It's more of a team now and we all work together." The administrator told us, "The staffing has much improved. We have six new staff who are good and dedicated."

We found evidence that people would be safely supported by staff who were trained and knowledgeable in the event of managing emergency situations. Members of staff had attended training in emergency aid awareness. One member of care staff demonstrated their understanding of this training; they acted out the actions that they would take in the event of a person becoming acutely unwell and had the need to be resuscitated. The provider wrote in their PIR that all staff had attended fire safety training and members of staff confirmed that they had attended this training. Furthermore, each person had their own emergency evacuation plan, which staff members were aware of.

The provider wrote in their PIR, "All staff undergo a rigorous recruitment and selection process" and "We obtain an enhanced DBS. We also obtain 2 written references and check the source of these references." Members of care staff described their recruitment process, which entailed an interview and all of their required checks were obtained before they were allowed to start their job. One member of care staff said, "I filled in my application form. Then they [management team] asked me to go for an interview. I had to go through procedures to make sure I was safe before I started. This included having a police check and I was asked for two written references." One service manager explained the recruitment process and said, "We do a DBS [Disclosure and Barring Service police check]. Two written references have to come back before they [member of staff] can do a 'shadow shift'. I speak to the person who has provided the reference and ask them if they are happy with everything and if there is anything else they needed to add." Another service manager told us that they were involved in the recruiting of new staff and had explored any gaps in prospective employees' employment histories during the applicants' face-to-face interviews. They said, "I would ask them [applicant] to explain what the breaks [gaps] are." They added that they were satisfied with the explanations that the applicants had given. Information we hold about the provider told us that there was a disciplinary procedure in place; this was used when members of staff failed to meet the provider's expected standards in providing people with safe and quality care.

People's risks were assessed and measures were in place to manage the risks. Members of care staff were aware of such risk and gave examples of how they supported people to keep them safe as much as possible. Examples included having the right amount of staff to support people on a one-to-one basis when going out in the community and when going swimming. One service manager said, "The risk assessment is an enabling tool, not a disability tool. So, basically, enabling people to do things in the safest way. When people are out and about you can't take the risk away. It's managing the risk you know about."

People were helped to take their medicines as prescribed and we saw that staff ensured that people had enough to drink to safely swallow their tablets. Medicines administration records [MARs] demonstrated that people had their medicines as prescribed. One service manager told us that they carried out audits on people's MARs and said that the audits were, "To look to see if there are any discrepancies. I have found none." One member of care staff told us that, due to a person having their medicines as prescribed, this had reduced the incidents of when they experienced seizures related to their epilepsy. The member of care staff added, "The person's seizures are very well-managed and they have only need two lots of PRN ['as required'] medication in the last five years."

The provider wrote in their PIR that in the last 12 months there were seven incidents in relation to the management of people's prescribed medicines. However, people had not experienced any harm and remedial action was taken to reduce the risk. This included, for example, the retraining and assessment of responsible member of staffs' competencies in helping people to take their medicines.

Medicines were stored safely and securely and the quality of the medicines was maintained by the regulation of the temperatures of where they were stored. Staff were trained in the management of people's medicines and were assessed at least once each year to ensure that their training was embedded into their

practice. One service manager said, "Every one [staff] has an annual medication observation." Records showed that staff had attended training and were assessed to safely help people with taking their prescribed medicines.

Good

Is the service effective?

Our findings

Members of care staff told us that when they first started their employment they had induction training, which included both practical and theoretical training. The practical-based induction training included new members of care staff watching more experienced care staff at work before, gradually, applying their learning into practice. One member of care staff said, "I've been going through things with them [more experienced members of staff]." We saw the member of care staff being supported by a more experienced colleague when they were supporting one of the people to go shopping. Another member of care staff said, "When I first started I had no confidence. Everyone [staff] helped you." They also told us that they were able to ask anything they wanted to as no question was viewed by other staff members as being "silly."

The provider told us in their PIR that there was a training programme for staff members to attend. Members of staff confirmed that they had the training to be able to meet people's individual needs and their training records supported what we were told. Examples of training included managing people's epilepsy; dementia and autism. Staff also received health and safety training, such as learning about practical moving and handling techniques. One member of care staff told us how they benefited from attending training; they said, "I recently did first aid and behavioural [managing people's behaviours that challenge] training. It was a refresher. It was good to refresh your memory but also to learn new things." Another member of care staff said, "I've learnt a lot. So much that I wouldn't be able to do the job without the training."

The provider wrote in their PIR that staff were regularly supervised and had attended an appraisal of their work performance within the last two years. Staff told us that they felt supported to do their job and had attended one-to-one supervision with one of their managers. The supervision enabled both parties to review the member of staff's work performance and training needs. In addition to these one-to-one supervisions, staff attended other support sessions, which included an appraisal. One member of care staff said, "We now have goals set, such as certain training we need or want to do. For the next meeting we will discuss and review these." They also told us that during their supervision and appraisal sessions their supervisor tested their knowledge following training, to ensure that their training was understood and applied into their practice. The administrator said, "Staff are being valued and they know they are being appreciated."

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this 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 provider told us in their PIR that 18 people were having their liberty, rights and choices restricted in any way as part of their planned care. Records demonstrated that DoLS applications had been made to the appropriate authorising agencies and the outcome of their review of the applications was awaited. Where restrictions were imposed these were based on people's risk assessments and in their best interests. Restrictions included the use of assistive technology to alert staff of when people left the internal premises of their home: this was the least restrictive method compared to the locking of people's doors. Other restrictions included the use of lap belts when some people were seated in their wheelchairs and individually designed chairs.

Members of staff were trained in the application of the MCA and were able to demonstrate their understanding of the legislation. One service manager said, "Everyone is assumed to have mental capacity unless they have an assessment to show otherwise. The option you consider has to be the least restrictive as possible and to be in their [person's] best interest." One member of care staff said, "The MCA has five key principles and it is about assessing people's mental capacity and how their personal choices and preferences are met in their best interests."

People told us that they had enough to eat and drink and one person said, "I'm never hungry." Relatives also told us that their family member had enough to eat and drink. People were given a choice of what they wanted. One person said, "My favourite is chicken curry. Oh yes we have that here. I like to eat out at the [name of public house] [and I have] sausage and mash and a glass of cider." Another person said, "Staff ask us what we would like to eat." We were also told by one more person that they were looking forward to their lunch and tea; they said, "We are having macaroni cheese and garlic toast for lunch and I am having a cheese quiche for tea later." We saw that their chosen lunch and tea-time menu was prepared; this showed us that the person's choice of what they wanted to eat was valued. We also saw one member of care staff ask another person what they wanted to eat for their lunch. Their choice of soup was prepared by staff for the person to eat. One member of care staff said, "We put two choices on the menu and if they [people] don't want what is on the menu, we do something different. Sometimes we are cooking five separate meals."

Members of care staff were aware of people's individual nutritional needs. One person's relative said, "Staff have to mulch [mash] [my family member's] food." One member of care staff told us, "There are SALT [speech and language therapist] guidelines in the correct type of foods, equipment and textures of food. Such as mashed food and thickened drinks and to avoid [hard to swallow] skins [of food]." We saw people were being helped to eat and drink, if this was needed, and this included thickened drinks being given on a plastic teaspoon to reduce the risk of the person choking. 'Pack-up' meals were being prepared for some of the people to take out when they were due to go out to have a picnic in a country park.

The provider told us in their PIR that members of staff were trained in supporting people with their food and drink by artificial means. One person had their food and drink by such means and we saw that they were showing signs of good nutritional health due to the condition of their skin and hair. We found another person was on a special diet to manage their health condition; staff had access to specific dietary guidelines regarding managing the person's diet; they were seen to be monitoring the person's nutritional intake in line with these dietary guidelines.

People were looked after in a way which helped them keep well as possible. One person told us that they were under the care of a physiotherapist and had instructions by them to follow. They said, "I do my physio every day." They also told us that they were under the care of a GP for the assessment and treatment of their health condition. One service manager told us that people had access to community psychiatric professionals to help manage their mental health conditions. People's care records also showed that people

had access to other health care services, which included dentists and chiropodists.

Good

Is the service caring?

Our findings

People had positive things to say in how they were looked after. One person said, "The staff are nice. It is nice to live here." However, on two separate occasions we saw that the engagement of people with staff could have been warmer. For instance, we saw two members of staff remind a person to remain independent, with making their own health care appointments and telephone calls, more by instruction than by encouragement. Nevertheless, we saw other occasions where members of staff were kind to people and included them in conversation and asked after their well-being. For example, one person was warmly greeted by members of care staff when they entered the kitchen area. We saw the same members of care staff speak with another person about what they were doing and taking an interest in their activities. We also heard staff members involve people in discussions about their activities of going shopping after having their lunch. Furthermore, we saw a member of care staff remind another person to wash their hands and this was done in a respectful and kind way.

The premises maximised people's independence, privacy and dignity. Kitchen areas were accessible for people to practice their independent living skills of food preparation and washing up. Bedrooms were en-suite and for single use only. Communal rooms were available for people to eat, watch television or a place to be quiet. External premises offered garden furniture for people to sit outside; we saw two people sitting in the sunshine and were relaxed in doing so.

The provider wrote in their PIR, "Each individual has a detailed support plan in place that is a live document and reviewed a minimum of every 6 months. The people we support and their circle of support are included in the writing of these plans and they also include other health professionals input if required. These work alongside risk assessments health support summary plans, and health records for a holistic approach to support." Members of care staff told us that there was a key-worker system in place. The key worker was the main member of staff who was responsible for including people and their relatives in discussion about what people wanted to do and about their planned care. However, one person's relative told us that although they were not involved in the writing of their family member's care plan "we are asked what we think." Where people were able to, they had signed their care plans to show that they had been involved and agreed to their planned care.

One member of care staff told us that improvements had been made in how people were cared for; they said, "I think the care is a lot more person-centred, because of the [registered] manager's structures that have been put in place. You work around the person's involvement with their one-to-one activities [meaning people not systems come first]." Other members of care staff were aware of the values and principles of good care. One member of care staff said, "People should be able to do things that they want to do and knowing that we are here to support them." People told us that they were enabled to do the things they wanted to, which included when they wanted to get up and go to bed. One person said, "[I] go to bed when I like and get up. Staff knock the door about 8:30." Another person told us "I get up at 6:00am and go to bed at 10:00pm." People's care records demonstrated that people's choices in how they wanted to be looked after were taken into account. One person told us that they requested to have a change of bedroom and their request was valued. They told us that this change of room had improved the quality of their sleep. Another

person told us that they had chosen the colour of the paint of their room and one relative told us that they had chosen the colour of the paint of their family member's room on their behalf.

The provider told us in their PIR, "Strong links are upheld with families/friends…" Care records showed that people were supported to maintain contact with their relatives and opportunities were created for people to make friends. Community recreational and work-related activities enabled people to meet other people who lived elsewhere. In addition, competitive activities, such as a gardening competition, brought people together from each of the individual houses to compete against each other. One member of care staff told us that one of the people from another of the houses visited them to have chat and drink. One service manager also described how some of the people visited other people living at the home, as they had made friends. We saw one person knew the names of the people who they lived with and were happy to introduce us to them. There were planned changes to move two people to live in another of the on-site houses. One of these people said that they were aware of the changes and, as part of the transition, had visited the house where they were due to live.

Information regarding advocacy services was available for people and staff to access, if they had a need to. The registered manager was able to name the advocacy services used and said that these were used to support people in making decisions about their care. One member of care staff said, "An advocate was invited [to attend a person's review of their care]." Advocacy services are organisations that have people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's individual needs were met in relation to the management of their continence and mobility needs. Members of care staff also were aware of people's individual communication needs. One member of care staff said, "You get to know them [people]. Such as if a person is in pain, the verbal noises they make. We use objects of reference. When [name of person] is shown their wheelchair they know they can go out." The member of care staff expanded on this and said that it was by the level of enthusiasm the person showed, which would determine if they wanted to go out, or stay at home. People's care records also provided staff with guidance in meeting people's complex communication needs. This included, for example, pointing to parts of a person's body to ascertain their response and to determine where they were experiencing pain. One member of care staff said that, as they knew people as individuals they "could pick up on people's moods." They told us that this had helped them support people with "appropriate" activities to promote their sense of well-being

However, we found that not all people's communication needs were met. We heard one member of care staff give a person detailed information about their medicines in a way that they would find difficult to understand.

People's care records, which included risk assessments, were kept up-to-date and were reviewed with the person. One member of care staff said, "The care files [records] are updated by the keyworkers and these are generally reviewed with the people we support." Members of care staff told us that they found the information in people's care records was easy to follow. One member of care staff said, "The care files are set out differently now and they are so much easier [to follow] than what they used to be."

To maintain people's well-being and community integration they were supported to take part in a range of recreational and work-related activities. These included, for example, swimming, shopping, eating out and attending day services. One person said, "I go to music therapy on a Thursday. I enjoy that. We take turns what we play. I play Bingo on a Wednesday night. I bought my bedroom furniture with the winnings. I like to watch TV" and named their favourite television soap opera. Another person said, "I did the hoovering today in the hall. I did gardening. I like Bingo and watching [name of comedy programme on television]. I go banger racing in Cambridge. I like to go to the pub with my friends from here." On the day of our visit people went shopping, had a picnic and went to day services. One service manager told us that, with a member of care staff, two of the people were on a week's holiday spent at an English sea-side resort.

People were supported to follow the religious faith of their choosing. One person told us that they enjoyed the occasions when they went into the community to practice their faith with fellow worshippers.

The provider told us that, in response to complaints they had received, remedial action was taken to monitor and review staffing numbers and the quality of staff members' work. The record of complaints showed that remedial action was taken to address people's concerns and improve the quality of people's care. This included, for example, improving the management of one person's continence needs. Members of care staff were aware of the provider's complaints procedure and their roles and responsibilities within this

procedure. One member of care staff said, "I would listen to what was being said; record it and pass it on to my [service] manager." There was easy-to-read information in relation to the provider's complaint procedure and this was contained in people's individual care records.

Good

Is the service well-led?

Our findings

We received a number of positive comments about their leadership and management of the home. On a number of occasions members of care staff described the registered manager as being "approachable". One relative said, "We have spoken to the management about changes. In the past there have been many staff changes, this is very upsetting for [name of family member] It seems very settled now. [The] management [are] open to listen and staff do what they can." The administrator said, "In the last year we have had three managers. We are finally getting improvements and changes are being done. We have had a lot more support since [name of registered manager] has been here. Changes have been put into place and staff are adhering to these. There is more stability of the management team within people's homes."

A local contracts and placement officer told us that, since the registered manager started working, they had made positive changes: this included the way that people were looked after and how staff were supported. In addition to this feedback, the local contracts and placement officer added that they found the registered manager had an open and transparent style of leadership. Furthermore, we were told that the registered manager was willing to continue to improve the standard and quality of people's care based following their contract monitoring visits.

We saw the registered manager visiting each of the people's houses during which they spoke with both staff and people in a calm and inclusive way. They had a good knowledge of people's individual needs and people knew who they were and liked them. One person said, "I can go any afternoon, to see the [registered] manager and chat about anything."

People were given opportunities to make suggestions about their care. One person told us that they attended 'residents'' meetings and said, 'You can say anything and what you want changed." They gave an example of having their request valued to have a change of room. Minutes of 'residents'' meetings demonstrated that other people had made suggestions and that these had been listened to. This included, for example, suggestions in relation to a change of menu and an increase in the range of activities, which included going on a picnic.

Some people's relatives had completed surveys to share their views about the quality and standard of care that their family member was receiving. Actions were taken to improve relatives' concerns, which included the recruitment of more permanent staff and the provision of a mini-bus to help people access the community.

Members of staff were also provided with opportunities to make suggestions during staff meetings and during their one-to-one supervision and appraisals. One member of care staff told us that, during their one-to-one supervision, they had requested training in dementia awareness and said that they had attended such training. Another member of care staff told us that, since the registered manager came into post, the frequency of staff meetings "have been more regular." They also said that the staff meetings were where they could, "Share any concerns that you have about people's needs. They [the management] go around asking if we have any ideas [to improve their work conditions and the quality of people's care]." They told us

that this included improving the cleanliness of people's homes and to try out new recreational activities for people to take part in.

The provider told us in their PIR that there were a number of quality assurance systems in place to ensure that people received safe care. One system included the management and supervision of staff when, "performance related issues are addressed, this includes setting actions plans for improvement and objectives for development. All staff have read their job descriptions and Skills For Health Code of Conduct to ensure they are fully aware of their role and what is expected." Another of these quality assurance systems included management teams who had contact with Royal Mencap Society–Broadoaks. The PIR told us that, "The service manager visits the services daily and monitor the quality and practice. The service operations manager visits the service at least once per week and the area operations manager visits at least once per month, this enables all managers to talk to staff and people who live there, addressing issues…" We received the PIR when we required it and this document demonstrated that there was an ongoing review and monitoring of the standard and quality of people's care.

The registered manager had submitted notifications when these were required and the information in these told us what actions they had taken to improve the safety of people living at the home. In addition, the submission of this required information demonstrated their understanding of the responsibilities of a registered person. We made them aware of the requirement to submit notifications should any person have an authorised DoLS in place.

Members of care staff were aware of the whistleblowing policy and when this was to be used. One member of care staff said, "If you have a concern with someone in your team and is not working to the five values [the provider's values], then you need to report them to the [service or registered] manager or using the internal whistle blowing line. It [whistle blowing] protects your confidentiality." All the care staff who we spoke with said that they had no reservation in raising their concerns about any poor care practice they witnessed or suspected people were being placed at risk.

Community links were forged by people being enabled to access a range of activities, which included shopping, engaging in sporting activities and visiting places of worship to practice their faith.