Care Management Group Limited

St Nicholas Glebe

Inspection report

6 St Nicholas Glebe
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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

This comprehensive inspection took place on 28 November 2018 and was announced.

St Nicholas Glebe is a supported living service that can accommodate up to six people.

On the day of our inspection four younger adults with mental health care needs and learning disabilities were living together at 6 St Nicholas Glebe. The accommodation was owned by a Housing Association and consisted of one bedroom self-contained flat and five single-occupancy bedrooms with a shared communal lounge, kitchen, toilets and showers.

People's care and housing are provided under separate contractual agreements. This inspection only looked at people's personal care and support as the Care Quality Commission (CQC) does not regulate premises used for supported living.

The supported living service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include the promotion of choice, independence and inclusion, so people with learning disabilities and autism can live as ordinary a life as any citizen.

This inspection will represent the first time we have rated the service because they were newly registered with the CQC in November 2017. We have rated the service 'Good' overall and for all five key questions, 'Is the service safe, effective, caring, responsive and well-led?'

The service has had the same registered manager in post since they registered with us 12 months ago. A registered manager is a person who has registered with the CQC to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People received a safe service where they were protected from avoidable harm, discrimination and abuse. Risks associated with people's needs including the environment, had been assessed and planned for and these were monitored for any changes. People did not have any undue restrictions placed upon them. There were sufficient staff to meet people's needs and safe staff recruitment procedures were in place and used. Where people needed assistance with taking their medicine this was monitored and safely managed in line with best practice guidance. Accidents and incidents were analysed for lessons learnt and these were shared with the staff team to reduce further reoccurrence.

People received an effective service. Staff received the training and support they required including specialist training to meet people's individual needs. People were supported with their nutritional needs. Staff identified when people required further support with eating and drinking and took appropriate action. The staff worked well with external healthcare professionals, people were supported with their needs and

accessed health services when required. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act (MCA) were followed.

People received support from staff who were kind and compassionate. Staff treated people they supported with dignity and respected their privacy. Staff had developed positive relationships with the people they supported, they understood people's needs, preferences and what was important to them. Staff knew how to comfort people when they were distressed and made sure that emotional support was provided. People's independence was promoted.

People received a responsive service. People's needs were assessed and planned for with the involvement of the person and or their relative where required. Service delivery plans were personalised and up to date. People received opportunities to pursue their interests and hobbies, and relevant educational, vocational and social activities were offered. There was a complaints procedure and action had been taken to learn and improve where this was possible.

The service was well-led. The monitoring of service provision was effective because repeated shortfalls were identified or resolved. There was an open and transparent and person-centred culture with adequate leadership. People were asked to share their feedback about the service action was taken in response.

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.

There were robust procedures in place to safeguard people the provider supported from harm and abuse. Staff were familiar with how to recognise and report abuse.

Risks people might face were identified and managed appropriately at both an individual and service level. The provider had suitable systems to monitor accidents and incidents and learn from these.

Staff recruitment procedures prevented people from being supported for by unsuitable staff. There were sufficient numbers of suitable staff deployed to keep people safe and respond promptly to their needs and wishes.

The environment was clean and tidy and staff knew how to prevent the spread of infection.

Medicines were managed safely and people received them as prescribed where the service was responsible for this.

Is the service effective?

Good

The service was effective.

Staff had the right mix of knowledge and skills to meet the needs and wishes of people they supported, through effective training, supervision and work performance appraisals.

Staff routinely sought the consent of the people they supported. Managers and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat and drink enough to meet their dietary needs. People received the support they needed to stay healthy and to access health care services as and when required.

Is the service caring?

Good

The service was caring.

People the provider supported, their relatives and professional representatives were all complimentary about the standard of support they, their loved ones or clients received from St Nicolas Glebe.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Staff consistently demonstrated warmth, respect and empathy in their interactions with people they supported.

Staff used a variety of communication methods to ensure people understood the information they needed to express their views and make choices.

Is the service responsive?

Good

The service was responsive.

People were supported to live an active and fulfilling life within their home and the wider community. The provider ensured people had access to a wide range of stimulating and meaningful social, educational and vocational activities that reflected their interests.

People were supported to maintain relationships with people that mattered to them. People had an up to date, personalised service delivery plan (care plan), which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and choices.

People were involved in discussions and decisions about their care and support needs.

The provider had suitable arrangements in place to deal with people's concerns and complaints in an appropriate and timely manner.

When people were nearing the end of their life, they received compassionate and supportive care.

Is the service well-led?

Good

The service was well-led.

Managers at all levels were highly regarded by people the provider supported and their relatives. People felt the managers were accessible and approachable.

The provider's values underpinned their governance framework and there were robust procedures in place to assess, monitor and improve the quality of service delivery.

People, their relatives and staff were involved in developing the service. Their feedback was continually sought and used to drive improvement. The provider encouraged staff to reflect on their practice and learn together as a team.

The provider worked in close partnership with external health and social professionals, agencies and bodies.

St Nicholas Glebe

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 was conducted by a single inspector over one day on 28 November 2018. The inspection was announced and we gave the provider five days' notice of the inspection because we needed to be sure people who use the service, managers and staff would be available to speak with us during our inspection.

Prior to this inspection, we reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. In addition, we considered information that had been sent to us by other agencies and contacted commissioners who had a contract with the service.

During our inspection we spoke in-person with all four people this provider currently supported and a range of managers and staff including, the registered manager, the regional director and two support workers. We also looked at a range of records including service delivery plans (care plans) for all four people who lived at 6 St Nicholas Glebe, three staff files and other documents that related to the overall management of this supported living service. In addition, we received written feedback from four relatives and friends of people the provider supported and three external professionals including, a project manager representing a local authority's learning disability team, a community mental health worker and an Independent Mental Capacity Advocate (IMCA).

Good

Is the service safe?

Our findings

People were protected from the risk of harm because there were processes in place to minimise the risk of abuse and incidents occurring. People told us the staff who supported them helped them learn the skills they needed to stay safe in their home and in the wider community. One person said, "Yes, I do feel really safe living here." Another person gave us a good example of how staff helped them manage and budget their finances safely.

Detailed policies were in place in relation to safeguarding and staff whistleblowing procedures. We saw safeguarding was a fixed agenda item at monthly staff meetings. Staff had received training in relation to these aspects of care and support. Safeguarding investigations were carried out and lessons learned were shared with the staff team. Staff understood and told us about their responsibilities to protect people's safety. For example, staff understood how they could support people to look after their finances safely and minimise the risk of individuals being financially abused when travelling and/or shopping independently in the wider community. One member of staff told us, "If I saw anything untoward happening here I would tell the [registered] manager straight away and her boss [regional director] as well." The registered manager was also clear about processes and when to report concerns to the local authority, police and the CQC.

Risk assessments were in place and staff were knowledgeable about what action to take to reduce risk. Measures were in place to reduce identified risks people might face, which ensured they could live their lives as independently as possible. Where risk was identified staff knew what action they should take and how to support people who needed help to safely manage their finances, travel independently in the wider community and prevent or manage behaviours that might be considered challenging. For example, several staff we spoke with were familiar with people's personalised behavioural support plans and knew what action to take to prevent or manage incidents of challenging behaviour that might occur at the service. Records showed all staff had received positive behavioural support training.

Accidents and incidents were recorded and analysed for themes and patterns to consider if lessons could be learnt and these were shared with staff. The registered manager gave us a good example of situations where they had used incident reporting to identify trends and develop risk prevention and management plans which had resulted in a significant decrease in the number of incidents of challenging behaviour involving people they supported.

There were plans in place for emergency situations. For example, there was an emergency plan in place in case of fire, adverse weather conditions or damage to the premises. Service delivery plans each contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills in the homes of the people they supported and received on-going fire safety training. Staff knew what to do in the event of an emergency and demonstrated a good understanding of their fire safety roles and responsibilities.
Maintenance records showed environmental health and safety checks in relation to gas safety and electrical installations, portable electrical appliances, water temperatures; fire risk assessments and equipment,

including fire extinguishers and alarms, were routinely carried out.

People were protected by the prevention and control of infection. The environment was clean and tidy and staff knew how to prevent the spread of infection. Staff had access to equipment to maintain good food hygiene practices, such as different coloured chopping boards. Cleaning responsibilities were allocated to staff and checks were routinely carried out. Records indicated staff had received up to date infection control and basic food hygiene training, and there were clear infection control and food hygiene policies and procedures in place. Staff were knowledgeable about what practices to follow to prevent and control the spread of infection.

People were supported by sufficient numbers of staff who had the right mix of experience and skills. People told us there were always enough staff on duty in their home to support them. The registered manager told us staffing levels were tailored according to the individual needs and wishes of the people they supported. The providers' approach to planning the number of staff that would be on duty was flexible and routinely reviewed staff rotas in response to people's changing needs and circumstances. One member of staff also gave us several good examples when additional staff were bought in to ensure prearranged social activities happened, such as a trip to watch a film at a local cinema or a group meal out for to celebrate someone's birthday. Several staff said they had enough quality time to spend with people so that support could be provided in a meaningful way.

The provider had safe staff recruitment checks in place. Records indicated when an individual applied to become a member of staff, the provider's human resources team carried out appropriate checks to ensure staff were of good character and were suitable for their role. This included looking at people's proof of identity, right to work in the UK, employment history, previous work experience, employment and character references and criminal records (Disclosure and Barring Service) checks. The DBS check provides information on people's background, including any convictions, to help providers make safer recruitment decisions and prevent unsuitable people from working with people in need of support. The provider also routinely carried out DBS checks at two yearly intervals on all long serving staff to ensure their ongoing fitness and suitability for their role. The registered manager was responsible for interviewing all prospective new staff and checking any gaps in their employment history.

Where people were being supported by staff to take their medicines, this was managed safely. People had their own lockable medicines located in their flat or bedroom where medicines handled by staff could be securely stored. Service delivery plans contained detailed information about their prescribed medicines and how they needed and preferred them to be administered. We saw medicines administration records (MARs) were appropriately maintained by staff authorised to handle medicines on behalf of the people they supported. There were no gaps or omissions on MAR charts we looked at. People had their medicines routinely reviewed by their prescribing healthcare professional. Staff had received training about managing medicines safely and had their competency to continue doing so was regularly assessed. Audits were routinely carried out to check medicines were being managed in the right way.

Good

Is the service effective?

Our findings

The provider ensured staff had the right knowledge and skills to deliver effective care to people they supported. Staff were required to complete a thorough induction, which included shadowing experienced staff during their shifts. The induction, which was mandatory for all new staff, covered the competencies required by the Care Certificate, which is an identified set of standards that health and social care workers adhere to in their daily working life. It was mandatory for all staff to complete learning disability, autism and mental health awareness training. Staff demonstrated a good understanding of their working roles and responsibilities. Staff spoke positively about the training they had received and felt they had undertaken all the training they needed to effectively carry out their roles and responsibilities. One member of staff said, "CMG provide all the training, which there's plenty of."

Staff had sufficient opportunities to review and develop their working practices. We saw the provider operated a rolling programme of regular one-to-one supervision meetings and annual appraisals with the registered manager and group meetings with their co-workers. Several staff told us these meetings helped them reflect on their working practices and identify their training needs.

Consent was sought before care and support was provided. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's capacity to make decisions was assessed and best interest decisions were made with the involvement of appropriate people such as relatives and staff. The MCA and associated Deprivation of Liberty Safeguards were applied in the least restrictive way and correctly recorded. Any application to do so for people living in their own homes must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. People's care plans continued to include guidance for staff regarding consent and an individual's capacity to make important decisions about how they wanted to live their life. For example, we saw mental capacity assessments in place in relation to people managing their finances, personal care and medicines.

We also saw people using the service signed their service delivery plan to indicate they agreed to the support provided. Records showed all staff had received mental capacity and Deprivation of Liberty Safeguards (DoLS) training. It was clear from comments we received from the registered manager and staff they were knowledgeable about how to work in line with the Mental Capacity Act.

People were supported to eat and drink enough and maintain a balanced diet. People told us the quality of the meals was 'good' and they always had a choice about what they ate and drank. Typical comments included, "The food is nice", "We talk about what we're going to eat at our tenant's meetings and staff sometimes come shopping with us to buy the food we're going to cook" and "I've got a menu I keep in my room, but I don't have to stick to that. Sometimes I go out shopping on my own to buy food I like." Service

delivery plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. All staff had completed food and nutrition training.

People had access to the health care services they required. People had individual health action plans that made it clear to staff how they should be meeting their specific health care needs. In addition, we saw people had a hospital passport, which is a document designed specifically for people with learning disabilities. The aim of the passport is to provide medical staff, including ambulance and hospital staff, with important information about an individual's personal and health care needs and wishes, should they be admitted to hospital. Staff were knowledgeable about people's healthcare needs and requested healthcare support as and when this was needed, and followed the advice given. We saw a diabetes action plan had been developed with input from a diabetes nurse and all staff had completed diabetes awareness training in response to an individual's changing health care needs. There was good communication between staff and health care professionals, including GP's, psychiatrists, speech and language therapists and diabetes nurses.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. People told us they were happy with the support they received at St Nicholas Glebe. People spoke positively about the staff who supported them and typically described them as "warm" and "friendly". Feedback we received included, "I love living here…I would recommend it", "It's a good place…All the staff are nice" and "I get on well with my keyworker…All the staff are great."

Community health and social care professionals were equally complimentary about the quality of the service provided by this supported living service. Typical comments included, "My clients have told us on several occasions how much they enjoyed the facilities and care provided by staff at their new home", "I've found the attentive, caring and professional attitude of all the staff who work at the service to be uplifting…I have no hesitation in recommending this supported living service to people with learnings disabilities, carers and professionals" and "Since living at the service the person I advocate for has become much more settled, happier and relaxed."

Relationships between staff and people were friendly and positive. We saw people looked at ease and comfortable in the presence of staff and conversations between them were characterised by respect and warmth. It was clear from comments we received from staff they knew the people they supported well and the things and people that were important to them. Staff knew people's preferences and the things they found upsetting or which might trigger distress.

People had their independence promoted. Typical feedback we received from people about how staff respected their right to maintain and develop their independence included, "It's great having my own place to live where I can be more independent", "Living away from my family has given me a chance to grow emotionally. Staff encourage me to be more independent and do things like buy my own food and do some cooking." and "Staff helped me get a job as a volunteer in a shop and travel on buses."

Staff told us the confidence of one person they support who was a risk of becoming socially isolated has significantly improved in the last 12 months, to the extent they now work as a volunteer in a local charity shop and can travel on public transport. It was also clear from comments we received from the registered manager they were proud of the progress this individual had made to develop their independent living skills in such a short period of time. A staff member gave us another good example of how they had helped a person to develop their independent living skills by encouraging them to do more of their own personal care.

In addition, people's service delivery plans included detailed information about people's dependency levels and more specifically what they could do for themselves and what help they needed with tasks they could not undertake independently. For example, it was clear who and when people were responsible undertaking various independent daily living tasks, such as food shopping, cooking a meal, cleaning their room and/or communal areas and checking their finances.

People had their privacy and dignity promoted. People told us staff always addressed them by their preferred name and never entered their flat or bedroom without their expressed permission. People also told us they had been given keys to lock their flat or bedroom door. Staff knew how to protect people's privacy when providing personal care. Service delivery plans contained detailed information about how people wanted staff to preserve their privacy and dignity and meet their personal care needs. The service had a designated 'Dignity Champion' whose primary role was to ensure staff continued to be aware of the importance and how to promote the dignity of people they supported.

The service ensured people they supported maintained positive relationships with people that were important to them. People told us they were not aware of any restrictions on times their family members or friends could visit them at home. One person said their family often visited them at St Nicholas Glebe, while another person told us, "After lunch I'm going to visit my family and stay there for tea." In addition, a community professional commented, "Staff are always welcoming and polite whenever I've visited the service." The registered manager told us they encouraged people's next of kin to be involved in making decisions about the supported living support their loved one received where this was appropriate.

Staff understood and responded to people's diverse cultural and spiritual needs and wishes. Typical comments we received from people they supported included, "I often to go church on Sunday on my own, which staff don't mind", "Some of the black staff sometimes help me make Caribbean style food I like and they know how to look after my hair properly" and "We celebrated black history month here the other month." We saw information about people's spiritual and cultural needs and wishes were included in their service delivery plans. The provider had up to date equality and diversity policies and procedures in place which made it clear how they expected staff to uphold people's human rights and ensure their diverse needs were respected. Records indicated staff had received equality and diversity awareness training. Staff demonstrated a good understanding of people's personal histories, cultural heritage and spiritual needs and wishes. This helped them to protect people from discriminatory practices or behaviours that could cause them harm.

Communication was good and people were given information in accessible formats. When necessary, people had access to advocacy services if they required support making decisions. This meant that people were supported to make decisions that were in their best interest and upheld their rights. There was a 'key worker' system in place so that people had a staff member allocated to them to provide any additional support they may need. Regular 'keyworker' meetings were held with the person so that people could express their views.

Staff were aware of the importance of ensuring information about people they supported was kept confidential. People said they felt comfortable talking to staff in confidence. The provider had a confidentiality policy and records indicated it was mandatory for all staff to receive confidentiality training as part of their induction.

Good

Is the service responsive?

Our findings

People received personalised support which was responsive to their needs and wishes. People had their needs assessed before they began using the service to check that their needs were suited to the service and could be met. People were involved in the service delivery planning process and their preferences about the way they preferred to receive their support was accurately recorded and staff were knowledgeable about these. For example, people's strengths, likes and dislikes, life history and preferences for how they wanted their support to be provided.

People were involved in routinely reviewing their service delivery plan. As people's needs changed this was reflected in their service delivery care. The registered manager told us they continually reviewed service delivery plans to ensure people's changing needs were properly recorded.

People were supported to make informed decisions and choices about various aspects of their daily lives. People told us staff supported them to make choices every day about the care and support they received. One person told us, "I can get up and go out when and where I want", while another person remarked, "I often arrange for staff to take me out when I want." A member of staff gave us a good example of how they encouraged a person they supported to choose what they wanted to wear by showing them various items of clothing from their wardrobe each morning.

People received information in accessible formats. People's service delivery plans included a detailed communication passport which outlined peoples preferred method of communication and communication needs. For example, one plan made it clear to staff if they did not speak to this individual in a concise way they might become confused which could trigger their distress. We saw staff communicate with people in appropriate ways and use objects of reference and pictorial prompt cards to help people make informed decisions about what activities they did, what they wore and what they ate. Staff were also knowledgeable about people's communication needs. We also saw people were provided with information about safeguarding, complaints and their health care action plan in an accessible format which was available in 'easy read' and pictorial versions. There were photographs of staff in the communal lounge to help people identify people who worked at the service.

People were supported to follow their interests and live active fulfilling lives'. People told us they had plenty of opportunities to choose to engage in all manner of meaningful social, educational and vocational activities. Typical feedback included, "We go out bowling and for lunch together every week, which we all like doing. I also go to college to learn how to cook", "This year I went out for a meal in a restaurant for my Birthday and we've all been to Brighton for the day" and "I work in a charity shop now and sometimes I go shopping and to aerobics with staff." During our inspection we saw people went out bowling and for lunch with staff. We saw people's service delivery plans reflected their specific social interests and hobbies they enjoyed. We also saw a weekly schedule of the activities they had chosen to participate in that week was displayed in their flat or bedroom.

People who were identified as being at risk of social isolation were appropriately supported by staff. One

person said, "I didn't use to like going out much before I came here, but now staff have helped me get a job…I like going out with my friends in the house as well", while a community professional remarked, "Staff are trying to ensure the people they support have meaningful life's, not just at the house, but also in the community. They have supported my clients to take on lots of opportunities in the wider community, such as joining a gym and doing voluntary work."

The provider had a complaints procedure which they followed. People said they knew how to make a complaint if they were dissatisfied with the supported living service they received and were confident that any concerns they might have would be dealt with by the provider. A community professional told us, "I have been liaising with the registered manager about a particular matter and I have found she goes to a lot of trouble to ensure the issue was resolved." We saw people the provider supported had been given a copy of their complaints procedure which was also available in an easy to understand simple language and pictorial format. All complaints were recorded along with the outcome of the investigation and action taken. We saw that staff had acted to investigate a complaint and had resolved the concern.

People's preferences and choices for their end of life care were recorded in their service delivery plan. People's families were involved in working with their loved one and the staff at the service to ensure people's wishes were supported. The registered manager also told us they were in the process of helping people decide if they staff or external medical professionals to attempt cardio-pulmonary resuscitation if required, and that any decision taken not to attempt cardio-pulmonary resuscitation would be clearly recorded in a person's service delivery plan and respected by staff.

Good

Is the service well-led?

Our findings

The leaders of this supported living service had the right skills, knowledge, experience and integrity to manage it well. The service had a hierarchy of management with clear responsibilities and lines of accountability. The registered manager was supported by a line manager known as a regional director. People the provider supported, their relatives and professional representatives all spoke positively about the way the service was managed. People said the registered manager was ever present in their home and always accessible. A community professional added, "I have a very good relationship with the [registered] manager who is always very professional."

The registered manager understood their responsibilities and sent us the information they were required to such as notifications of changes or incidents that affected people they supported.

The service had an open and inclusive culture and understood the importance of gaining the perspective of people they supported. One person said, "We have lots of meetings with our key-worker and the other people who live here to talk about what food we like to make and what activities we like doing." We saw the service had a range of mechanisms in place to obtain people's feedback including, individual monthly meetings with their designated key-worker and regular group discussions with their fellow tenants. People were also invited to complete a satisfaction survey about the service they received at St Nicolas Glebe.

Staff were also actively involved in developing the service and were encouraged to propose new ways of working. Staff had opportunities to regularly attend team meetings with their co-workers. Fixed agenda items that were always discussed at these team meetings included staff training, safeguarding incidents, the changing needs of people they supported and health and safety issues.

There was clear oversight and scrutiny of the service. The management team carried out a rolling programme of audits to check that staff were working in the right way to meet people's needs and keep them safe. These audits included checks on service delivery planning and risk assessing, management of medicines, staff recruitment, training and supervision, fire safety, accidents and incidents, infection control and food hygiene, finances, and health and safety. Through the governance systems managers had identified many issues which they had begun to address. For example, they had used incident reporting to identify what might cause a person's behaviour to escalate and with support from mental health professionals had developed positive behavioural management plans to mitigate the identified risk.

There was a clear vision and culture that was shared by managers and staff. The culture was clearly person-centred and staff knew how to empower people to achieve the best outcomes. The registered manager told us they routinely used group team and individual supervision and work-performance appraisal meetings to remind staff about Care Management Group's (CMG) underlying core values and principles. This helped the registered manager gauge staff's understanding of the provider's values, share information on 'best practice' and monitor how well staff were following guidance.

Staff worked in close partnership with other agencies and bodies which included local authorities, Clinical

Commissioning Group's (CCG's) and NHS Trusts. The registered manager told us information about people's changing needs and best practice ideas were often appropriately shared with these agencies. This ensured staff received all the external professional guidance and advice they required to meet the needs of the people they supported.