Wessex Regional Care Limited

Wessex Regional Care Domiciliary Service

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Wessex Regional Care Domiciliary Service is a domiciliary care provider. At the time of this inspection 47 people received personal care support from the service. The service supported people who have learning disabilities, people with autism and older people either in their own homes or in supporting living accommodation.
Not everyone using the service receives a regulated activity. CQC only inspects the service being received by people provided with 'personal care', help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a domiciliary care provider and there were also people receiving care in supported living accommodation. These were small, residential properties where people received individual support. There were no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate the houses were supported living accommodation.

People's experience of using this service and what we found
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The service applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

People were supported by staff trained to identify the signs and symptoms of abuse who would not hesitate to report poor practice of colleagues.
Risk assessments were completed, and risks minimised however positive risks were promoted to enhance people's experiences.
Staff were mainly safely recruited. Improvements were instigated to the recruitment process during our inspection. We have made a recommendation about the recruitment procedures.

Staff were trained and assessed for competency in administering medicines and a comprehensive policy and procedure ensured that errors were thoroughly investigated if they happened.
People were supported to keep their homes clean and staff had a good understanding as to how to minimise the spread of infection.
Accidents and incidents were analysed, themes identified and risk assessments reviewed.

Assessments of need were completed before the provider agreed to provide a service to ensure the care provided would be suitable for them and manageable.
Staff completed an induction when commencing working for the provider. Regular supervision ensured staff felt supported in their roles.
People needed support tailored to their needs in order to maintain their diet, this was provided, and people were encouraged to eat healthily.
People received support to attend GP and hospital appointments and the provider had forged positive relationships with commissioners to enable a smooth process when people's needs changed.
The service was compliant with the requirements of the Mental Capacity Act 2005.
People told us they felt their staff were caring and kind and we heard staff speaking about people in a respectful way.

People were supported to participate in care planning and each month would participate in a review of their person-centred plan.
Most people and their relatives felt staff treated people with respect. Dignity audits ensured that staff practice was constantly reviewed to ensure it was respectful and supported people to maintain their dignity.

Care plans were person-centred and held sufficient information about people's likes, dislikes and aspirations.
The service met the requirements of the Accessible Information Standard.
People were supported to maintain and develop new friendships and relationships and to access a variety of activities both provided by the service and in the community.
Complaints had been dealt with according to the complaints procedure and staff and people were supplied with information about how to make a complaint.
The service was not providing end of life care to anyone when we inspected however they had been trained and had considered their approach when they needed to do so in future.

The management team were accessible and approachable. The culture of the service was empowering to people and staff.
The registered manager understood their responsibilities under the duty of candour.
The registered manager had clear oversight of the service and when things went wrong, practice was reflected on and learning taken from it.
Extensive quality assurance research was completed and the provider ensured that it investigated negative responses in an attempt to improve service experience for people.
The provider had positive links to health and social care services.

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

Rating at last inspection
The last rating for this service was good (published 23 March 2017).

Why we inspected
This was a planned inspection based on the previous rating.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Wessex Regional Care Domiciliary Service

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 Care Act 2014.

Inspection team
The inspection 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service also provides care and support to people living in '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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before we inspected Wessex Regional Care Domiciliary Service, we looked at the information we already held about the service. We used the information the provider sent us in the provider information return. This

is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.
We looked at notifications. Notifications are sent to us by the service to tell us about significant events. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives about their experience of the care provided. We spoke with 16 members of staff including the provider, registered manager, locality manager, human resources manager, training manager, senior support workers and support workers.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at nine 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 reviewed.

After the inspection
We received all of the additional documents we had requested including policies and procedures, audits and quality assurance questionnaires.

Good

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 good. At this inspection this key question has remained the same.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives felt safe receiving support from Wessex Regional Care. One person told us, "Yes, I feel very safe with the support workers who visit once a week". A relative told us, "I think my son does feel safe" and another said, "I assume my daughter is [safe], as she is always happy when I speak to her".
• Staff were trained in safeguarding and were regularly updated to ensure they were current in their knowledge.
• When asked, staff were able to tell us possible signs and symptoms of different types of abuse and the actions they would take in the event they suspected someone had been abused.
• Staff would also use the whistleblowing procedures to report colleagues' poor practice if necessary. One staff member said, "If I went into a service and saw something I was really not happy with, I would report it to the manager that morning". Staff also told us they would approach outside agencies such as the Care Quality Commission (CQC) if they felt concerns they had raised had not been dealt with by the provider.

Assessing risk, safety monitoring and management
• Peoples care files held risk assessments about all aspects of their life. Possible hazards associated with areas including health and medicines, communication, community access and substance misuse had been considered and when necessary actions put in place to mitigate risks to the person.
• The provider supported people to take positive risks which enabled them to have more experiences and a more fulfilling life. Risks such as supporting a person with epilepsy to bath by remaining outside the door and calling out regular checks rather than remaining in the room with them. This provided the person with privacy and dignity and was respectful without compromising the persons safety.
• Risk assessments were clearly written and enabled staff to have clear instructions as to how to support a person safely.

Staffing and recruitment
• Staff were mainly safely recruited however we found three staff recruitment records had gaps in their employment histories. Providers are required to obtain full employment histories from the time staff left full time education. This meant the provider was not able to consider whether the persons background had affected their suitability to work with people. In the three examples, there were several years when no employment history had been recorded. We spoke with the human resources manager and the registered manager about this and before we had concluded our inspection the missing information had been sourced and appropriate plans put in place to ensure this did not happen in future.

We recommend that the recruitment procedures are reviewed and made more robust.

• Staff told us that there were sufficient staff to support people. In one of the supported living accommodations, a person had needed a change from one-to-one staffing to two-to-one staffing without notice. This had been a challenge to achieve as there were also requirements for either two male or one male and one female staff member. The provider had been proactive and had sourced an agency who were able to provide the same few staff on a regular basis which suited the person who disliked too much change, and who worked alongside staff employed by the provider.

Using medicines safely
• Medicines were safely managed. Staff were trained by the in-house trainer and before being allowed to support people with their medicines had to pass a written and practical test of their competence.
• Medicines were mainly supplied using monitored dosage system (MDS). This is prepared by the pharmacy and people or staff select the correct medicines and administer and complete a medicine administration record sheet, MAR.
• People were supported to be independent with their medicines. Risk assessments were completed, and people's care plans reflected the specific support they needed to safely take their medicines. Care plans were reviewed regularly to ensure that the support remained suitable.
• Medicines documentation was comprehensive including forms to transfer medicines to relatives if people were visiting family for a period of time, a medicines discrepancy form was used for any errors, omissions and refusals and a medicines root cause analysis was completed if a medicines error or near miss occurred.

Preventing and controlling infection
• Staff participated in training in infection control, delivered by the in-house trainer.
• We asked staff what they understood about infection control. All staff we spoke with had a good understanding of minimising the spread of infection. One staff member told us, "During personal care we use gloves and aprons and dispose of them after use. We also try to stop cross contamination and wash work tops before preparing food for example".
• We visited four supported living properties and staff had supported people to keep their homes clean and hygienic.

Learning lessons when things go wrong
• Accidents, incidents and near misses were reported and analysed on a service by service basis and in an overall annual report prepared for the provider by a consultant. Analysis showed that none of the reported incidents were due to health and safety issues, they were mainly due to behaviours or medical condition related injuries.

Good

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 good. At this inspection this key question has remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• An assessment of needs was completed for all people before the service agreed to provide a package of care. This system was becoming challenging as local authorities were reluctant to disclose any details of people before the registered manager agreed to provide the care. The provider had remained firm and would not agree a package without first fully assessing the person.
• Assessments were holistic; addressing all relevant areas of a person's situation, needs, health, behaviours and their hopes and aspirations. Once fully assessed a care plan would be devised and risks assessed so staff were prepared to begin to support the person.

Staff support: induction, training, skills and experience
• Staff completed an in-house induction on commencing working at Wessex Regional Care. The provider had a training manager who delivered most of the training to staff and to some other providers in the locality.
• The induction was thorough and when staff commenced working within each of the different people's homes, or supported accommodation, they would have an additional induction to become familiar both with people and their duties. Staff had to complete the Care Certificate to a competent level before working unsupervised with people. The Care Certificate is an agreed set of standards encompassing the skills, knowledge and behaviours expected of roles in health and social care.
• Staff told us that the training was good, one staff member said, "The trainer isn't too laid back but gets on with everybody. It's a nice setting and some of the training may be serious but they keep it light hearted".
• Staff were supervised monthly and senior staff completed observations of practice regularly to monitor competence and to identify any training needs.
• The provider produced a monthly training newsletter. This contained details of training courses scheduled for that month and any available spaces. It also had a specific section which focussed on providing information staff needed to be aware of. We saw newsletters focussed on the Accessible Information Standard (AIS), self-neglect, first aid changes to practice, and building resilience. The newsletters were informative and an accessible way to educate staff informally.
• Training had recently been delivered to people using the service. One person had a partner who had epilepsy. They had requested to attend the epilepsy training course, so they could be more informed about the condition. Other people had completed food and hygiene, passing the test along with staff that supported them. This would continue to be developed and more courses were to be made available to people or adapted to meet their needs.

Supporting people to eat and drink enough to maintain a balanced diet
• People needed different levels of support with maintaining a balanced diet. Support workers would shop and cook for some people, they would offer choices and plan menus with people but prepare and cook meals for them. Other people needed to have prompts or support when cooking and advice on healthy foods.
• The provider supported people with specialist dietary needs as required. One relative wasn't satisfied with the support their family member received. They told us, "[Name] does need help with food preparation and shopping is being encouraged so they can eat healthily. But they do tend to buy a lot of biscuits, chocolates and sweets and have put on quite a bit of weight". The person was able to make unwise choices about food however staff did advise them of healthy choices.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were supported with their health needs. If someone became unwell, staff would arrange a GP appointment and would support people to hospital and dental appointments as needed. A relative told us, "Support workers take my son to the GP if he needs an appointment". Another relative said, "My daughter can access a GP or hospital appointment with the help of a support worker".
• Staff knew people well and would alert relatives and GP's if they were concerned for someone's wellbeing.
• The provider had positive links with commissioners and when one person's needs had changed significantly had been able to approach them and seek additional funding to cover increased staffing levels.

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.
• We saw MCA assessments in care records to cover aspects of peoples care and when the person was deemed to lack capacity there were best interest decisions to support people when significant choices were made.
• One person had capacity, but relatives also held a Lasting Power of Attorney (LPA) for them if the person lost capacity in the future. An LPA is a document that enables nominated people to make decisions on your behalf should you lose capacity. A copy of the LPA was on file.
• The service was working within the principles of the MCA.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and relatives told us that staff were caring. A person told us, "The support workers that I have are always kind and caring, Yes very". A relative said, "I believe so, kind and caring towards my son". Another relative told us, "Yes very kind and caring. They always have her welfare uppermost".
• Staff spoke about people in a kind and respectful way and some staff had worked with people for several years and had forged positive relationships with them and their relatives.
• People's needs were always considered and whenever possible the provider sought to meet these needs creatively. One person had a love of water but did not respond well accessing community swimming pools. The provider had agreed a cap on their water meter bill with their supplier on the persons behalf, so they could use as much water as they wished without costs being prohibitive. While this is usually agreed when someone in a household has significant personal care needs, this had been agreed for the person's well-being. When we visited, the person was in the shower for over half an hour and was heard laughing and was clearly very relaxed afterwards.
• Staff received training in equality and diversity as part of their induction and this training was updated regularly.
• Care plans were written in a person centre way and this ensured that peoples protected characteristics under the Equality Act 2010 were considered and met when possible.

Supporting people to express their views and be involved in making decisions about their care
• The provider supported people to participate in the assessment and care planning process as fully as was possible. If people were not able to participate but had relatives who were involved, they were also included in care planning.
• Person-centred plans were reviewed each month and people met with their key workers to discuss their plans and make adjustments. Meetings were also held with family members and commissioners or social workers. These meetings were held in people's homes which people told us they appreciated.

Respecting and promoting people's privacy, dignity and independence
• Staff recognised they worked in people's homes and respected them as such. One staff member told us, "[Person's name] sometimes wants to have private time. They will tell us and rather than them go to their room, we go to the office until they are happy for us to be with them again".
• People told us they felt they were treated with respect. One person told us, "The support workers treat me

very well… yes I think so". One relative agreed saying, "Yes I believe they do treat him with respect and dignity". However, another relative told us, "According to my [person], the support workers are not always respectful, especially when it comes to their weight as they don't want to be weighed".

• The provider had appointed dignity champions who completed regular dignity audits of people's service provision to ensure it respected their dignity. The audits included observations of staff practice ensuring it is respectful and in line with the person-centred ethos.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were person-centred and reviewed monthly to ensure they were current with people's needs and wishes.
• People were involved with their care plans if they wanted to be. One person enjoyed sitting with their key worker each month and planning training courses and ideas to add to their plan to enable them to get a job of their choice in future.
• Care plans held information on people's likes, dislikes and aspirations. This was particularly helpful to staff if people lacked capacity to make choices or had difficulties in communication.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• The provider held the status of being Makaton Friendly. This means that as an organisation they had understanding of people communicating in different ways, they were welcoming to people who had learning, or communication difficulties and they used Makaton symbols or images in their head office and training rooms to enable people to access them.
• Staff had completed courses in Makaton as some people used Makaton for communication. One person used a small selection of signs and understood a few Makaton symbols or images so staff used a combination of these to communicate with them, with significant success.
• People had person centred assessments which had sections on communication needs and staff supported people in the most effective and preferred way for each individual.
• Information was presented to people in both written and pictorial format. One person had requested that all information be sent in text format as due to being visually impaired they found that adjusting the font size on text messages was the best way for them to read information.
• The provider was compliant with the Accessible Information Standard.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The provider supported some people for short visits on a daily or weekly basis while other people had 24-hour support.

• People were supported to access activities such as day services; support staff ensured that people were up, bathed and ready for transport.
• The provider supported people on a more individual basis. One person had previously worked, and staff were supporting them to investigate how to gain specific qualifications to work in their chosen occupation. Other people were supported to access local sports facilities, shopping and voluntary work.
• The provider supported people with leisure opportunities. A local nightclub ran closed sessions for people who had disabilities and staff supported people to attend. The provider also held events such as barbeques and parties for people that received their services which were well attended. A five-a-side football team also took place, the team was formed with people who used the service.
• People were supported by staff to maintain existing and forge new relationships with friends and relatives. One person had met someone they knew some years before at one of the nightclub events and was supported to telephone them and visit them by support staff. The relationship was new and the person we spoke with was thrilled and very happy.
• Some support activities had reduced. One person told us, "My cooking activities have been reduced by three hours a week since January due to lack of staff availability". We asked the provider about this and the reduction in hours was due to the commissioners of the service funding only enough time for staff to prepare a meal for the person rather than for them to support the person to prepare their own meal. The provider had not been able to increase the hours provided.
• Relatives told us that their family members enjoyed activities such as football, shopping, dances, trips to the pub and other sports arranged by the provider.

Improving care quality in response to complaints or concerns
• The provider welcomed complaints and concerns and were proactive in investigating them. We saw three complaints, not all substantiated, however all dealt with appropriately and in a timely way. All had been dealt with by the provider and none had been escalated to external agencies.
• Both people receiving support from the service and staff were provided with a copy of the complaint's procedure and as part of their induction, staff were also trained in the procedures and their role in receiving complaints. One person told us, "I would talk to the manager if I needed to complain".

End of life care and support
• When we inspected the service, no-one was being supported with end of life care. The registered manager told us, "We have trained at [local hospice] and have end of life documentation ready and contacts to utilise for support".
• The provider would be utilising the SWAN approach, the aim of which was to promote dignity, compassion and respect for people and their relatives at the end of their lives.
• People had been supported to discuss their decisions around their funerals and through this the provider had established who would like to remain in their own homes if possible.
• The provider had established positive working relationships with GP surgeries and district nurses, both of whom would be essential to people when being supported with end of life care.

Good

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 good. At this inspection this key question has remained the same.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The registered manager and provider had developed a person-centred culture in the service. Core values of providing a service that promoted dignity, was respectful and developed people's skills of independence were known by staff and reflected in their practice. The culture empowered people and staff to develop skills in order to achieve outcomes.
• Peoples individualism was reflected in the service they received, their care records and in their goals and aspirations. There was no 'one size fits all' approach to care and support.
• The registered manager, and other members of the senior management team, were approachable. Staff felt able to approach them directly.

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
• When things went wrong the provider was open and informed relevant people under the duty of candour.
• The registered manager also informed the CQC about significant events within their services using notifications. They indicated on notifications if the events were covered by their duty of candour.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The service had a manager registered with the CQC. 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.
• There was a clear structure to the services, area manager oversaw different individual aspects of the service and additional managers were in place to take responsibility for human resources and training.
• Staff had regular supervisors and told us they would be happy to approach them, the provider, and the registered manager, with concerns or ideas for how the service could be improved.
• The registered manager had clear oversight of the service. There were frequent audits to ensure that care practice, safety and documentation were at an acceptable standard. Findings of audits were shared with staff who worked with the management team to continually improve services.
• The provider reflected on practice if things went wrong. Accidents and incidents were analysed, and learning was taken from these events and shared amongst the team to minimise future risks and to develop service provision.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Quality assurance questionnaires had been completed by staff and people. We saw the analysis of one of the questionnaires. People had responded with mainly positive answers about whether they were happy with where they lived, if they were supported to visit friends and relatives and in all other areas.
• All negative responses had been followed up with individuals to ascertain why, for example, they were unable to visit family when they wanted. Reasons included family living a long distance away. The specific comments had been shared with senior managers who were working to address issues.
• Quality assurance questionnaire were sent to people on a quarterly basis to ensure continual assessment of quality. In addition, each service had a supply of feedback forms available to people which could be sent confidentially to the registered manager at any time.
• Staff questionnaires were also sent on a quarterly basis. These were themed, for example one asked for feedback about support and supervision and a future questionnaire was about staff well-being.
• The provider supported charities and held events such as a barbeque to raise funds for causes chosen by people who used their service.
• The service was also reviewed each quarter by one of the commissioning local authorities to ensure they were providing care at an acceptable standard. All actions requested by the local authority had been met.
• Team meetings were held every two months in each individual supported living staff team. This was an opportunity to discuss both issues pertinent to the people living in each service and those concerning the service as a whole. Senior managers alternated in their attendance of team meetings, so staff could address things directly to them.
• There was a 'Wessex Forum'. This was a meeting of people who used the service who represented themselves, and others, when making decisions and discussing service issues. A venue for the Christmas party had been discussed as had suggestions for charities to support. People were supported to attend these meetings which took place at the providers head office.
• The provider issued a newsletter with news about people, staff and the company. Photos of people enjoying day trips, participating in volunteering and of their birthdays were included along with charitable events such as sponsored cycle rides completed by staff. This kept people informed of news as well as providing them with a regular link to people in different accommodations and to staff and managers they may see infrequently.

Working in partnership with others

• The provider worked in partnership with all relevant health and social care agencies. For example, information on people's communication needs had been shared, with their permission, with the local hospital. This was to ensure that, if the person was admitted when away from the service, information about their communication needs would already be held by the hospital. If they were admitted from the service, they would have a hospital passport with them.