London Care Limited

London Care (Lingfield Lodge)

Inspection report

Lingfield Lodge
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
London Care (Lingfield Lodge) is a domiciliary care service situated in East Grinstead, West Sussex. They provide personal care for people living in extra care housing in a purpose-built block of flats that could accommodate up to 48 people. Extra care housing is designed for people who need some help to look after themselves, but not at the level provided by a residential care home. People living in extra care housing have their own accommodation and have care staff that are available when required either contracted or in an emergency.

The service supported people who were living with a range of complex needs including mental health, learning diability, physical disability and dementia. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. There were 47 people being supported by London Care at the time of the inspection.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Right Support:
People's mental and physical health needs, and associated risks, were not always assessed appropriately so that staff could provide safe and responsive support. The service did not have enough appropriately skilled staff to meet some people's needs and support them effectively. Feedback from people and professionals was that the skills and training of staff on supporting people with complex needs could be improved. Some people received support with their medicines although these were not always managed safely and effectively. There were sufficient staff to support people although feedback from people on the timings and lengths of calls were mixed.

Right Care:
People did not always receive personalised care. Some care plans lacked detail about people's physical and mental conditions and what staff should do to support these responsively. Staff understood how to apply the principles of safeguarding people, and how to recognise and report abuse. There was a lack of personalised approach to identifying individual risks associated with people's mental and physical health conditions. The provider's quality assurance systems had not identified these shortfalls. Some people received support with their medicines although these were not always managed safely and effectively.
Right Culture:

People told us that management support and approach was inconsistent and that interim management arrangements had not been as effective or consistent in their oversight of staff or their support. Quality assurance systems were not fully effective as they had not identified shortfalls identified in the full report. People's communication needs had been assessed and information could be provided to people in an accessible format. Complaints were dealt with in line with the provider's policy.

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

Rating at last inspection
This service was registered with us on 16 December 2021 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, person centred care and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

London Care (Lingfield Lodge)

Detailed findings

Background to this inspection

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

Inspection team
The inspection was undertaken by 1 inspector.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a short period notice of the inspection. This was because we needed to be sure the provider or manager would be in the office to support the inspection.

Inspection activity started on 9 March 2023 and ended on 14 March 2023. We visited the office location on 9 and 10 March 2023.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we currently hold about the service which includes statutory notifications. This is information the provider is required to send us. We contacted the local authority to gain feedback about the service. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people and 1 relative about the service they were receiving. We spoke with 4 care workers by telephone. We visited the provider's office on 9 March 2023 and spoke with the interim care manager, regional manager and team leader. We reviewed records that included 9 people's care plans, risk assessments and medicine administration records. We also looked at records relating to the management of the service, including policies and procedures, quality assurance systems, staff recruitment and training records. We contacted 7 professionals to obtain feedback about working with the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Some risks to people were had not been fully assessed and care plans did not have all the information staff needed to manage risks safely.
- For example, one person's summary stated that they had epilepsy and had tonic clonic seizures. There was no reference within risk assessments about what staff should do, or how they should support the person, in the event that a seizure occurred.
- Many people living at Lingfield Lodge were living with complex physical and mental health conditions such as learning disabilities, bipolar disorder, Schizophrenia. Risks associated with these had not always been assessed, or fully assessed, to mitigate situations when identified risks may occur, or provide guidance and actions for staff to respond to these.
- Two people with a mental health diagnosis and dementia had a in their care plan summary that stated, 'I have no medical condition or mental health illness that may leave me feeling confused'. Another person lived with a learning disability and diagnosis of Schizophrenia who had a documented episode of self-harm. Risks had not been assessed and guidance was not in place for staff to support the person with their anxiety and distress to prevent potential harm.

The provider had not done all that was reasonably practical to mitigate the risks people's health and safety. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Other risks had been assessed for people, with guidance in place for staff to support them. Risks to people's mobility, skin integrity and nutrition had been completed for example.
- People had detailed Personal Evacuation Plans in place to ensure that they were safely supported from Lingfield Lodge in an emergency.

Using medicines safely

- People's medicines were not always managed safely.
- Some people were prescribed 'as and when needed' or PRN medicines. Clear protocols were not in place for staff to follow when PRN medicines were needed. General information sheets were in place to guide staff on when PRN medicines might be needed for some health conditions. However, there were no person specific guidance on signs and symptom for that person, individual cues that indicate that the medicines is needed etc.
- When people required support with medicines, Medication Administration charts (MARs) were completed by staff but not always fully and correctly. We reviewed 4 people's MAR charts and identified a number of

gaps where care assistants had failed to record whether a medicine had been administered or not. A coding system was in place for staff to record reasons for any non-administration, but this had not been used by staff on occasions where gaps occurred. This meant that staff could not be assured that people were receiving their medicines. One professional said, "A patient had been without her glaucoma eye drops for 2 weeks, despite the fact that the staff had been signing the MAR chart saying it had been given. This was confirmed by the fact that there were no eye drops in her room."

● Feedback on medicines was mixed. Some people told us that staff supported them effectively while others highlighted shortfalls in practice. One person said, "There is one carer just walks through the door, gives me the tablets on the side and goes. She doesn't watch me take the tablets."

● Professionals we spoke to raised concerns about how medicines had been managed and overseen. One professional said, "I have consistently seen MAR charts where non-Parkinson's medication has run out for a 1-2 week period but unclear why. Parkinson's medication has been changed without the direction of the Parkinson's consultant, but the care manager is unclear why medication has been changed and unable to provide clear rationale." Another professional said, "The staff seem generally caring to patients but seem out of their depth when dealing with medication issues and it seems that there may be a lack of training."

The provider had not always ensured the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Medication care plans and risk assessments were in place. These detailed people's level of independence and what support they needed.

● There was clear information in place regarding responsibility for the storage of these medicines in people's flats.

Preventing and controlling infection

● People told us that there was an inconsistency with staff wearing appropriate personal protective equipment (PPE) when supporting them.

● Management informed us that it was policy for staff to wear masks and in communal areas people's flats, and masks, aprons and gloves when providing personal care. While some people stated that they observed their carers with appropriate PPE, many others highlighted an inconsistency of approach between staff. One person said, "One person does but no one wears masks." Another person told us, "Not all of them use gloves and not all of them use masks."

● One person highlighted concerns around the hand hygiene of some staff. They told us, "They don't wash their hands before they touch any food of mine. They don't wash their hands enough."

● Staff had received infection control training and that they had access to the PPE that they needed.

Staffing and recruitment

● There were enough staff to provide care to people.

● People and staff told us they felt there were sufficient numbers of staff to support them safely. However, some people told us that continuity of staff, timings and length of care calls often varied. We have detailed this more in the responsive section of the report.

● Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People told us that they felt safe from the risk of abuse. One person said, "They keep an eye on me. They say if there's any problem to let us know straight away."

● Staff had received safeguarding training and were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were aware of the signs of abuse and how to report safeguarding concerns.

● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority

● The manager had a system for recording and monitoring incidents and accidents. Staff understood their responsibilities for raising any concerns and reporting incidents and near misses.

● Records showed that incidents were reported appropriately.

● The registered manager regularly reviewed incidents to identify any trends that emerged.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

- Staff did not always have the right training and skills to support people effectively. Many people receiving care from London Care were living with complex needs, diagnoses, and health conditions such as learning disability, epilepsy, and a range of mental health needs such as bipolar disorder and Schizophrenia.
- Training records showed staff had not received specific learning disabilities, mental health needs or epilepsy training to support individuals effectively with their conditions. Since 1 July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. One staff member said, "We have a few people with mental health conditions. I want more training in that side of it." One professional said, "Staff are trying their best with the residents, but there is a wide spectrum of people with varying needs and conditions. This makes it difficult to train everyone in certain conditions, for example neurological conditions, and for them to understand certain needs."
- Professionals told us that they worked with the service to provide guidance and information for staff to support people with specific conditions, but that some staff did not possess the understanding and skills to support them with these effectively. One professional said, "With regards to people with advanced Parkinson's disease they often have complex care needs, and my personal view is (staff) cannot meet the care needs of this cohort of patients at this current time." Another professional said, "I feel at Lingfield Lodge, as some people are more independent, staff are not properly trained in certain conditions that can impact cognition and speech/swallowing."
- Some people told us that while staff supported them well with general personal care tasks, they felt that there were differences in skill level, knowledge and application of support. One person said about the medication support for their mental health condition, "Not all of them are skilled enough. Some deal out my tablets and say, 'what's this for?'. They don't know what they are giving me. They say, 'Why are you having that?' They ask me about what I have and what happens with that (the condition). Definitely could do with more training." Another person said, "Some are better skilled than others. Some are more 'with it' than others." Another person said, "I had 2 staff members last year who didn't know how to use a hoist for another client. They told me that they were winging it and hadn't been trained to use it."

The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Peoples' needs, and choices, were assessed prior to them receiving a service from London Care.
● The management of the service met with people before setting up their care package.
● Current evidence-based assessments were used to assess people's needs. For example, a Malnutrition Universal Screening Tool (MUST) was used to identify the level of nutritional risk for a person.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people needed support with food and drink and staff ensured they had sufficient amounts to maintain a balanced diet.
● People had nutrition care plans in pace to guide staff on how food was to be prepared, what support was required and what they would like their mealtimes to look like.
● Some people were more independent and chose to have their meals in the canteen available to them onsite at Lingfield Lodge.

Supporting people to live healthier lives, access healthcare services and support
● Care plans contained information on others involved in a person's care. For example, the district nurses or other specialists such as Parkinson's nurses.
● Wherever possible staff supported people to access services they required.
● People had hospital passports in place should they need to access health services in an emergency. A hospital passport provides important information about people's care and communications needs, including personal details, the type of medication they are taking, and any pre-existing health conditions.

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 MCA 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.

● Staff received training on the Mental Capacity Act and understood their responsibilities regarding MCA, and the importance of people being involved and making their own decisions.
● People were supported in accordance with the MCA. Consent was sought by staff when supporting them with their care needs.
● People's capacity was assessed on whether they could consent to specific decisions and tasks being undertaken.
●Staff worked with the local authority when capacity issues arose and were part of best interest decisions when required.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Feedback from people on the approach of staff was mixed.
- While some people indicated that staff supported them to meet their needs, others expressed a frustration with staff responses. One person said, "Certain carers seem to want to do as little as possible. They rush their jobs as they want to go out and smoke. There are always quite a few carers out there. I feel for the carers that don't smoke." Another person said, "I can tell the difference the older ones and younger ones. For example, the washing up. If I had two young people in, they would ignore that. The older ones see that straight away, the younger ones don't see it unless you prompt them." Another person told us, "One person said, "Carers are a bit slapdash since (registered manager) went off, as they know they don't have to worry about being pulled up on things."
- Many people did speak positively about the staff that supported them. One person said, "Carers are very friendly and have a chat." Other comments from people included, "Yes, I always have a natter with them as well. They are becoming like friends", and "the staff who are here are very nice."
- Our observations were that staff spoke to people respectfully. People looked relaxed and comfortable when talking to staff and discussing their care. One person said, "If I treat them with respect, I expect it back and I do get it back."
- Staff spoke about the people they were caring for with compassion and respect and the approach they took to their role. One staff member said, "My golden rule for myself the day I stop caring I will stop caring. Another said, "I've just been me and try to be as happy as possible. I chat and talk to people like a normal human being.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect. We observed staff knocking on people's doors within the scheme at Lingfield Lodge before entering. We observed staff supporting people to walk in communal areas and at lunchtime. They treated people with respect and kindness. One person said, "Yes, I feel there are staff I get on with. I look forward to the days they are on. I know if anything happens, they are there for me."
- People told us that staff protected their privacy. Information relating to people care was stored confidentially. GDPR project had been introduced following new guidance. GDPR is the General Data Protection Regulation which provided further protection of people's sensitive and personal data that is held within their care plans and of staff that are employed in the care home.
- People were supported to be as independent as possible. Care plans detailed some people's personal care routine and encouraged people to be independent in areas they could manage but also detailed where support was required. One person said, "They are following my instructions. I do most of it myself. I try and

be as independent as possible."

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were involved in planning their care and support.
● One staff member said, "I give them my time and include them in everything. It's involving them and taking the time with them."
● Staff provided people and their relatives with information about other organisations offering support and advice. For example, one person was referred to an Independent Mental Capacity Advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions such as where they live and about serious medical treatment options. IMCAs represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some people's care plans did not always fully reflect their physical, mental and emotional needs, or provide guidance for staff on how they provide the appropriate support.
- Several people that London Care supported at Lingfield Lodge had a diagnosis of learning disability or mental health conditions such as bipolar disorder and Schizophrenia. The care plans for 4 people living with a learning disability did not contain any details about how this impacted them or what potential risks it presented to them or others. There was little or no guidance on how staff should support them should impact their physical or mental wellbeing.
- Although some people told us they received the preferred timings of their calls and carers completed the full time, many people expressed concerns about the continuity, timings and length of their care calls. One person said, "I have such a variety of times that they come - this morning it was near 10am I was up all night, so I got myself up. I never know what time it's going to be."
- Many people expressed concerns with the amount of time carers spent supporting them during their allocated calls. One person said, "No they don't stay the full time as they have other calls to make. It's a general experience. I just expect it now." Another person said, "Some carers do stay, some don't stay the full time. Some carers can't be bother at all, they want to get in and out quickly and others sit and chat." Another person commented, "Sometimes they are rushed, especially in the evening when they are getting people to bed." One person stated they had seen some improvement in this area since raising it with the provider. They told us, "They didn't used to stay the full length of time, but they have got a little better since I put my foot down just after the new year. They were rushing."
- People's care plans included information such as details about their life history and interests, communication needs, family history and preferred personal care routines.
- Care plans also contained information about what supported people needed with regards to their oral care.

The provider did not fully assess or ensure that people's care fully reflected their needs and preferences. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

End of life care and support

- No one was receiving end of life support at the time of the inspection. Staff had previously supported people with end-of-life support and had received training.
- People's end of life wishes had been sought at their assessment. Some people made decisions to discuss this area, which was recorded by staff.

● Advance decisions in terms of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) had been recorded and contained information relating to people's power of attorney.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication and sensory needs had been assessed.
● People had communication plans in place which guided staff on how they wished to be supported. Care plans considered health conditions that may impact on people's communication and guidance was in place for staff to ensure they communicated effectively.
● When people had sensory needs, staff supported them. For example, if people had aids to support with their hearing, staff ensured they faced them when speaking.
● The provider had access to and had produced, information in different formats, such as braille. Information in larger print and other formats such as easy read would be accessible if needed.

Improving care quality in response to complaints or concerns
● The provider had a complaints system and people told us they felt comfortable to raise any issues.
● The provider had a complaints policy which was shared with people in their home files.
● People knew how to raise a complaint and who to raise this with.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems for identifying and managing risks were not fully in place. Risk assessments and care plans did not always contain all the information staff needed and quality assurance systems had not identified the shortfalls highlighted in this report.
- The oversight and quality assurance processes had not identified the need for the development of some people's risk assessments. Systems had not identified the need for development and improvements in training and provision of guidance for staff to understand and support individuals' complex needs. While medicines audits were in place, continued discrepancies in the recording of people's medicines meant that auditing systems were not fully effective.
- At the time of the inspection, the service was being managed by an acting manager while the registered manager was on extended planned leave. Prior to the acting manager being in place, the service was supported by interim leaders within the staff team.
- Many people and staff told us that they felt that the culture and approach of management had dropped and had not been as effective since the registered manager had been absent from the service. One person said, "I think (interim manager) has got too friendly with office staff. They'll sit there and take it in turns to buy meals. People respected (registered manager) but I don't think they respect office staff now." Another person said, "It's a bit chaotic. It's a nightmare. I just find with the office, it's very difficult to talk to someone in private as there's lots of people in there. It's hard for me to come back upstairs." One professional commented that in the absence of the registered manager, "It's not as stable as it could have been."
- Some people commented that this drop in management had impacted on the approach of staff. One person said "The carers congregate into the office. They do their calls. It's annoying when you want something, and they just sit there."
- While staff stated that they mostly received the guidance they needed to complete their roles, the inconsistency in management had impacted. One staff member said, "There are a few care assistants, it is like 'while the cats away'. There was a little pocket of carers that let the team down. The carers can say we just want (registered manager) back. I don't think a lot of care staff realise what there is to do." Another staff member said, "It has it's up and downs. I won't say it's perfect as it's not. It could be improved."

The provider had not ensured that effective systems were in place to monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Quality assurance systems were in place that effectively monitored other areas of service delivery. Spot checks and competency checks were undertaken with staff to ensure that good practice was maintained.
●Staff received regular supervisions to support their working practices. Themed supervisions were carried out in specific areas such as medication and mental capacity when issues of performance had been identified.

Working in partnership with others
● Staff and management worked with other professionals and specialists, such as district nurses, occupational therapists and the local authority falls team to support people's care when required.
● We have detailed within the report feedback from professionals in relation to the staff understanding of complex needs, medicines and training. One professional informed us that they had raised concerns with the local authority regarding areas of practice concern that they had identified and also raised directly with the provider.
● While concerns that had been raised directly by professionals had been taken on board by the provider, feedback was that progress in implementing improvements was ongoing. One professional said, "I think they should provide more training. We are pushing more training above the minimum standards. They are taking that on board."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had undertaken quarterly 'voice of the customer' surveys to seek people's feedback on their support. We saw records showing an improvement plan that had been completed following this feedback and any actions that had been taken.
● Some people told us that management responded to requests for support when they visited the staff office within the extra care facility. One person said, "I've been down there a couple of times to order more medication and they've sorted it out." Another person said, "When I do go down, they mostly sort things."
● The provider had implemented areas of continuous learning for staff. Apprenticeships had been offered for management and team leader roles to develop, while a project to further develop staff's knowledge of GDPR (General Data Protection Regulation) had been undertaken.
● Overall. staff told us they were supported in their role and that the management was approachable and friendly. Staff sad that communication was good. One staff member said, "It's very good to be honest. Everything that needs to be handed over is handed over. If they have a call about a meds change, we are told straight away."
● Management understood their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not fully assess or ensure that people's care fully reflected their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practical to mitigate the risks people's health and safety. The provider had not always ensured the proper and safe management of medicines.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that effective systems were in place to monitor and improve the quality and safety of the services provided.

The enforcement action we took:

Warning Notice