Apex Prime Care Ltd

Apex Prime Care - Newman Court

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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Apex Prime Care - Newman Court provides domiciliary care and support to people living in this 'extra care' housing project. Extra care housing is purpose-built or adapted single household accommodation, in a shared site or building. At Apex Prime Care -Newman Court the accommodation consists of individual flats in a purpose built complex, which are either rented or purchased with shared equity. The service provides support to older and younger adults who may be living with a physical disability, sensory impairment, dementia or mental health diagnosis. The service was supporting 33 people at the time of the inspection.

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.

People's experience of using this service and what we found
Overall people and their relatives were happy with the care provided. Their feedback included, "I'm very satisfied. I get everything I need" and "I would definitely recommend it." However, some feedback indicated there had been times when some staff had not been found to always have supported people respectfully and compassionately and on occasions some people reported they experienced their care as 'rushed'.

Staff understood people's preferences. People were supported to express their views and to be involved in decisions. Staff ensured people's privacy and dignity were upheld. They supported people to retain their independence.

Processes were in place to protect people from the risk of abuse. Potential risks to people had been assessed and managed. People received their medicines safely from competent staff. There were sufficient staff employed with the required skills to provide the amount of care commissioned for people. Infection control measures were in place in response to the COVID-19 pandemic. Staff reported any safety concerns and action was taken following incidents to reduce the risk of repetition for people.

People's needs were assessed with them and the delivery of their care reflected current legislation and guidance. Staff had the required knowledge and skills to provide people's care. Staff worked both within and across organisations to ensure people's health needs were met and they received effective care.

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.

People received personalised care which was planned around their needs. Staff supported people to be involved in a range of activities. Staff were able to support people to be cared for at home at the end of their life as per their wishes.

People reported the service was well-led. People overall and staff felt confident in raising any issues and most reported they felt heard. The registered manager understood their role and responsibilities. The provider had taken relevant actions following a complaint which was received recently. Processes were in place to monitor and evaluate the quality of the service provided. Staff worked across agencies, to ensure people received joined up care.

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 18 March 2021 and this is the first inspection.

The last rating for the service under the previous provider was good, published on 25 July 2018.

Why we inspected
This was a planned inspection.

Follow up
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? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Apex Prime Care - Newman Court

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

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection to ensure people we needed to speak with would be

available.

Inspection activity started on 8 April 2022 and ended on 14 April 2022. We visited the location's office on 8 April 2022.

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 had received about the service since registration. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
At the site visit we spoke with the registered manager, two senior care staff and a visiting health care professional. We observed staff supporting people in communal areas and reviewed a range of records. These included three people's care and medication records, staff supervision records and audits of the service.

After the inspection
We spoke with nine people and six relatives about their experience of the care provided. We also spoke with the regional manager, six care staff and received feedback on the service from a healthcare professional.

We continued to seek clarification from the provider to validate evidence found. A variety of records relating to the management of the service, including policies, procedures and training data were reviewed.

Good

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 good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. A person said, "I feel safe and looked after; I have no issues with feeling safe with the carers." Safeguarding was discussed with people at resident's meetings and people's rights were outlined in the provider's policies and service user guide. Processes were in place to ensure people's keys were safely stored and staff wore uniforms and name badges, to ensure people could identify them.

● Staff had completed the provider's safeguarding training during their induction and updated this annually. Safeguarding was also discussed with staff at their supervisions and staff meetings.

● Staff had access to relevant safeguarding guidance and understood the training provided and their role. A member of staff said if they had a concern, they, "Would raise it immediately with management." Staff reported concerns as soon as they were noticed and this had enabled one situation to be quickly addressed with relevant parties for the person's safety.

● Since the provider of the service had changed, the registered manager had not raised any safeguarding alerts, but understood how to.

Assessing risk, safety monitoring and management

● Staff had assessed potential risks to people, related both to their care and environment. Risks to people associated with moving and handling, falls, fire, the use of prescribed flammable topical creams, nutrition and their personal care were discussed and assessed with them. Where risks had been identified, appropriate measures were in place to manage them. For example, staff completed moving and handling training and where two staff were required to transfer people safely, they were provided. A person said, [The carers] know how to use the hoist and move me about very carefully in it."

● People could access staff support in an emergency 24 hours a day. A person told us, "One of the things the carers check is that you're wearing your alarm call, that you press if you need help."

● Information about risks was shared amongst the team and with appropriate parties. This was particularly important, as the provider was not responsible for either the premises or equipment. For example, we heard the registered manager and the scheme manager discuss how best to manage a potential risk to a person. We also heard a member of staff discussing a concern about a person's safety with the registered manager, to ensure they were aware.

Staffing and recruitment

● There were sufficient staff employed with the required skills to provide the amount of care commissioned for people.

● Some of the people and relatives spoken with told us although the care commissioned was provided, staff could on occasions finish the call early. Feedback included, "The carers are very stretched, especially the teatime to evening shifts, so I know they can't always stay the full time. As long as they've done everything I

need, I don't mind" and "Sometimes [the carers] are not there for the full time, but they try to make it up next time."

● Staff documented the length of people's care calls in their daily logs of which a percentage sample were audited monthly, no issues had been identified. We reviewed people's responses from the last annual survey and saw people had not identified call length as an issue. The provider was planning to introduce an electronic care planning system, which will make it easier to monitor the length of people's calls in real time and therefore identify and address any issues.

● There was no use of agency staff, so people had continuity of staff. A staff member said, "People get different carers but they know each one of us."

● The provider operated safe recruitment processes. The provider ensured the required pre-employment checks were completed including a Disclosure and Barring Service (DBS) check. The DBS check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● People had medicines risk assessments, which identified if they administered their own medicines or required staff support. Their medicines were stored safely in their flats. There was guidance for staff, including protocols for medicines people took 'as required' and body maps which showed them where to apply people's topical creams. Overall people were happy with the support they received. A person said, "My medication is all locked away and [the carers] open it up, count [the tablets] out and pass them to me to take."

● Staff received medicines training at their induction, which they updated annually and had medicine competency assessments to ensure they understood their training. Staff had access to the provider's medicines guidance and people's records included guidance for the administration of each medicine. Staff documented the administration of people's medicines on their medicine administration record (MAR) which was then audited for any gaps.

Preventing and controlling infection

● We were assured that the provider was using personal protective equipment (PPE) effectively and safely.

● We were assured that the provider was accessing COVID-19 testing for staff.

● We were assured that the provider's infection prevention and control policy was up to date.

● Staff received training in prevention and infection control.

Learning lessons when things go wrong

● Staff spoken with and the registered manager understood their responsibility to report any concerns or safety incidents.

● Staff documented incidents, falls and hospital admissions on logs and the actions taken to minimise the risk of repetition in people's care records. Information about any incidents was shared within the staff team and with external agencies where required, in order to identify any learning.

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.

This is the first inspection for this newly registered service. This key question has been rated good. 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

● People's care needs were assessed with them before their care commenced and regularly reviewed, including, if their needs changed. A person said, "When I came here I spoke with [senior carer] for an assessment of my needs. They asked me what I needed and that's what they stuck to. We had a review a few months ago and agreed to reduce my hours because I don't need as much help from them at the moment." The registered manager ensured staff could meet people's needs before they agreed to provide their care.

● People's care plans noted the planned outcomes for their care and how these were to be achieved. For example, how the person wanted their care to be provided or who they wanted involved in their care planning. People's support was planned in accordance with regulatory requirements and guidance.

● People had technology where required to promote their independence such as falls monitors and a pendent to request help if required. The provider was planning to introduce an electronic care records system to further enhance the delivery of people's care.

Staff support: induction, training, skills and experience

● Staff had the right competence, knowledge and skills required for their role. Staff completed a three-day on-line induction to their role and shadowed other staff, before they completed the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. Staff then had the opportunity to complete professional qualifications in social care.

● Staff completed training relevant to people's care needs in areas such as dementia, diabetes and continence. Staff updated their training annually. Staff received ongoing supervisions, spot checks of their practice and competency assessments. A member of staff confirmed, "We get the training and supervision and we are kept up to date. We get refreshers." Overall people felt staff had the required skills. A person said, "The carers cope with [my relative's] needs very well. Recently she had [an infection] and the carers observed it quickly – they were quick off the mark and alerted me to the problem so I could contact the doctor."

Supporting people to eat and drink enough to maintain a balanced diet

● People were provided with a two-course meal at lunchtime seven days a week by the housing provider as part of their rental charge. Staff supported people in the dining room with their meal at lunchtime if required or took people their meal in their flat if preferred. We observed staff supported people at their own pace. A person confirmed, "[The carers] are very nice. I see them helping in the dining room; the people that need help with eating, the carers help them and are very kind with the way they do that." Staff assisted people

with their breakfast and tea in their flat if needed.
● People's dietary support needs and preferences were documented in their care plan. Staff noted and monitored people's food and fluid intake if they were at risk of dehydration or from not eating enough.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
● Staff shared information across the team about people's care through their internal communication book. This ensured staff were updated about any risks or changes to people's needs they should be aware of. Staff identified issues which could impact upon people's health or wellbeing and shared them with the appropriate professionals.
● People had hospital admission forms on their records and in their flats which noted relevant information about their care in case they needed to be admitted.
● People could visit a chiropodist if needed onsite. This service was not funded as part of people's care, they paid separately. Staff referred people to other health professionals as required. A relative said, "If the carers have any issues or concerns, they take the initiative to deal with it. [On one occasion], they were worried and rang the doctor's straight away, then rang and let me know."

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 involved people in decisions about their care, to ensure their human and legal rights were upheld. A relative told us, "Before [my relative] moved in, we had a meeting with [a senior staff member] and discussed what she needs and how the carers would support her. [My relative] had her say and was fully involved at the time." People had signed their consent to their care where they had the capacity to do so.
● Where people had a power of attorney in place, a copy had been obtained, to enable staff to check what decisions, the attorney was authorised to make on the persons behalf. Where people lacked the capacity to make a specific decision, this had been assessed and a best interest decision made involving relevant people. Staff had undertaken training on the MCA and had access to the local authority MCA guidance for information.
● The provider's 'Decision making and the MCA' policy, did not reference the actions to take if a person was assessed as lacking the capacity to make a specific decision. There was no reference to the best interest principle and it's use to guide staff and supplement their training if required, this was fed back to the provider, who has not yet informed us of any planned changes. Although there was best interest guidance for staff on the provider's MCA tool, it had not been included or referenced in their policy.

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

● People and relative's feedback was mixed. Whilst overall it was positive, three relatives provided negative feedback. One relative reported, their loved one was happy, but, "Sometimes the staff are not very welcoming or friendly." Another relative informed us they had not always found all staff to be kind and compassionate. They had not always felt heard, respected or validated by all staff. This had been reported to the provider who was investigating. Other people told us care staff were caring and kind, their feedback included. "They're nice people, the carers; they've got a sense of humour so you feel it's not just 'business' to them. Right from the off, the carers were all nice to me." We observed staff treated people with kindness. A staff member told us, "I make cakes and I take them in. One lady it was her birthday and she does not have a family. I made her a cake and took her some daffodils."

● Staff training included equality and diversity and staff had access to the provider's guidance. The staff team were all female, which meant if people preferred a male carer, one could not currently be provided. We discussed this with the registered manager, who advised they had tried to recruit males to reflect the diversity of the people supported, but none had applied.

● Staff were informed about people's preferences in their care plans. A staff member told us, "People have preferred ways of having things done." People confirmed staff understood their preferences. A person said, "[The carers] use my preferred name, never [my given name]." Another person told us, "The carers know that I get good and bad days regarding walking around for instance. They know when I'm in pain and might need more help at that particular time."

● People's communication needs were noted in their care records and staff were informed of how to support people appropriately.

Supporting people to express their views and be involved in making decisions about their care

● Overall people and their relatives felt staff had the time and training they needed to provide care in a compassionate and personal manner. Feedback from some people and relatives spoken to indicated on occasions, some staff could be 'rushed.' A person said, "They [staff] don't stay for long for a chat – they're pushed for time." A relative reported their loved one could feel 'rushed' by staff with their shower. People's records noted staff did spend time chatting with people wherever possible. However, some care calls commissioned were of 15 minutes duration, therefore there was limited time to spend with the person. A staff member confirmed, "There isn't a lot of time but we do have a chat." The registered manager told us this issue had been raised with commissioners.

●Staff had failed to confirm if a person's family had been informed of their loved one's admission to hospital or to maintain contact as per the provider's hospital admissions policy. The provider was investigating this

incident to identify what actions they needed to take.
● Two relatives told us their loved one often declined aspects of their personal care. People's care plans instructed staff to encourage them to shower, where required. The provider was commissioned to provide people with a specific number of care calls, for a set length of time. This meant if a person resisted some of the care scheduled, staff did not have any extra time to go back later and offer it again, as they would be able to in a care home. Staff monitored this and fed back to commissioners where required if people did not accept the care as scheduled, or they needed additional support, to enable them to assess if a change was required to the frequency or level of care commissioned for the person.
● People said they did not mind which staff provided their care, but some said they would have liked a rota, to know which staff were due. We spoke to the registered manager who said rotas had been issued, but they were not always accurate as staff allocations then changed, due to staff absence. They did not provide rotas, with a view to updating people about any resulting changes. They advised they would look into doing this again once the electronic care planning system was introduced, as this would enable rosters provided to be more accurate.
● People were provided with information about the service in the service user guide when their care commenced. This included how to access an advocate if required. The provider's charter of rights set out people's rights, including freedom from discrimination.
● Staff involved people's families and external professionals when appropriate. People told us staff respected their wishes.

Respecting and promoting people's privacy, dignity and independence
● People told us staff treated them with dignity and respect when providing their personal care. Their comments included, "The carers are always respectful and very understanding." Staff told us how they ensured people's privacy and dignity were maintained.
● Staff understood and respected people's right to retain their independence. A person said, "I do what I can and [the carers] observe and only step in if I ask them to." A staff member told us, "We [staff] help them [people] to do things for themselves. If we are washing up we would get them to dry."

Good

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 good. 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

● People told us they had been involved in developing their care plans. A person said, "I went through the care plan the first time I came here, I met with the manager. They asked me everything you can think of about me, what I need, what I like, how I want things done; all of that, and it's all in my care plan." People's needs in relation to their protected characteristics such as disability and religion, had been identified. People were asked in the provider's annual survey if staff respected their protected characteristics, which they confirmed they had.

● Staff read people's care plans and understood their needs. A staff member said, "We get time in calls to read the care plan. If a new person moves in a copy is put in the office for us all to read."

● People had reviews of their care plan which was changed as required. A person said, "My needs have changed quite dramatically in the last 12 months, and the plan is updated to reflect that."

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.

● Staff documented people's communication needs and provided information in a suitable format where required. No-one currently required information to be provided in an accessible format.

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

● Staff ran on-site activities to address people's needs for social stimulation. We saw people enjoyed the activities provided, which enabled them to socialise and chat.

● The registered manager told us people particularly enjoyed the gardens at the complex, where people planned, planted and maintained raised planters. We saw a person enjoying their gardening.

● A hairdresser visited the service and Holy Communion was held monthly. There was also a resource centre next door to the service which some people attended and a supermarket nearby. Staff arranged internal events and external trips for people. For example, there had been a Halloween celebration and a summer trip to the seaside was booked. A member of staff confirmed, "We do games, bingo, raffle, quiz and communion monthly. We made Easter hats, we took them to Weymouth we take them out to lunch."

Improving care quality in response to complaints or concerns

● Records reviewed at the site visit showed no written complaints had been received since the provider of the service had changed. The registered manager told us of the actions taken to address a verbal concern received. They were able to demonstrate the actions taken with the relevant parties and commissioners to address the issue. Commissioners were also provided with details of any complaints or concerns received on a quarterly basis for monitoring.

● Following the site visit, the provider did receive a written complaint and they commenced an investigation, to identify what actions were required to address the issues raised.

● Some people we spoke with said they did not know how to raise a complaint. People were provided with information about how to make a complaint in their service user guide, the statement of purpose and the provider's complaints policy. People told us if they wanted to make a complaint, they felt comfortable speaking to the registered manager.

End of life care and support

● People's end of life wishes had been discussed with them and recorded where appropriate. Staff documented if people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) or Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in place.

● Where required hospice staff or the district nurses would support staff where people wished to be cared for in their home. Staff could access palliative care training and had access to the provider's guidance. A member of staff who had provided end of life care to a person told us they had felt well supported.

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.

This is the first inspection for this newly registered service. This key question has been rated good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● People's care records and service logs showed information about incidents had been captured, reviewed and actions taken. Incidents were reported on a weekly basis to the provider. However, since the change of provider there had not been a complete transition to ensure staff used all of the provider's required paperwork, for example, for incident reports. The provider was in the process of working with the extra care locations, to support them with transitioning to the required paperwork.

● The registered manager was supported in their role by their two senior carers and a regional manager. In addition they attended meetings the provider arranged for the registered managers.

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

● Overall people were happy with the care they received and most reported the service was well run. A person said, "I think it's run well. If ever I need anything, I can just knock on the office door. [Name of registered manager] and I get on very well; she's a good manager – helps you out if you need anything."

● The registered manager monitored the culture of the service and staff reported they felt well supported by her and motivated. Staff said, "We are a good staff team" and "It's really good [work]." The registered manager was visible within the service and well known by people. The provider also completed quarterly welfare and wellbeing checks with staff. The provider had taken appropriate action in response to the complaint received, to assure themselves of the culture of the service.

● The provider's statement of purpose set out their aims, objectives and principles for the delivery of the service. Staff had access to the provider's policies which they were required to read.

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

● There had not been any notifiable safety incidents which had occurred during the provision of the regulated activity where the registered manager was legally required to notify the person's representative. However, they understood their legal responsibilities to do so.

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

● People's views on the service were sought through reviews of their care, spot checks on care staff, resident meetings which were organised by the housing provider and an annual survey which was sent to people in

May 2021. The last survey showed a good rate of satisfaction. Overall people told us they felt listened to. A person said, "I do think [the carers] listen to people" and a relative told us, "I find [the management] do listen." Staff meetings were held, which enabled staff to express their views on the service.

Continuous learning and improving care

● The registered manager ensured audits were regularly completed of people's care notes, call times, medicine administration records (MAR's) and care plans. Records were also maintained of people's falls, infections and hospital admissions, in order to identify any trends. Staff spot checks, supervisions and reviews of people's care enabled them to monitor and evaluate staff's performance.

● The registered manager sent the regional manager a weekly report which encompassed all aspects of the service. For example, care plan and MAR audits, people's reviews of their care, complaints, safeguarding's, concerns, hospitalisations, staff supervisions, and CQC notifications. This ensured they were regularly updated about any issues. The regional manager advised, they had recently taken over the location and were due to complete their audit of the service.

● There was also external oversight of the service. The registered manager provided the local authority with a quarterly report on the service, which included all aspects. This ensured they were regularly updated about issues.

Working in partnership with others

● The service worked in close partnership with key organisations to support the provision of people's care. They worked with the local authority, the housing provider, district nurses, occupational therapists, pharmacists, community mental health teams and GPs in the area. They worked across agencies, to ensure people received joined up care.

● The registered manager attended a monthly meeting with the local borough council, where nominations to the extra care schemes were jointly discussed.

● Professionals provided positive feedback about the service and their working relationships with staff. They all reported the registered manager and staff were helpful and open.