Akari Care Limited

Lindsay House

Inspection report

Parbold Hill
Parbold
Wigan
Lancashire
WN8 7TG

Tel: 01257464177

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced and was conducted on 22 and 23 May 2017.

Lindsay House is located on Parbold Hill within the county of Lancashire, and is run by Akari Care. It is a two storey building, which was previously used as a vicarage. All rooms are of single occupancy. However, shared accommodation can be arranged, if required. Some bedrooms have en-suite facilities, although communal toilets and bathrooms are available. There is dedicated access for wheelchair users and a passenger lift is installed. Support is provided for up to 31 people, who require help with personal care needs. At the time of our inspection 26 people were living at Lindsay House.

The registered manager was on duty when we visited Lindsay House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run.

During our previous inspection, 13 July 2015, we found that the service was in breach of regulation, and that improvements were needed in relation to risk assessments, care planning, infection control and quality assurance. The service was required to make improvements in relation to the effective use of infection control measures, better risk assessment and quality assurance processes, and more effective staff deployment so that people's needs were always met. During this inspection, we found that improvements had taken place.

People and their relatives were happy with their care. They spoke highly of the staff, who treated them with kindness and respect. The planning of people's care was based on an assessment of their needs, with information being gathered from a variety of sources. We found that assessments had been conducted and people's needs had now been included in the risk assessment process and clear information was provided for the staff team. People had the care they needed. Care plans had improved, and were devised to address people's individual needs and were regularly reviewed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff understood how people's care was to be provided. Care was provided with people's consent, either verbally or more formally when needed in line with best interests decisions that met the requirements of the Mental Capacity Act 2005. Where necessary, applications had been made under the Deprivation of Liberty Safeguards. Where deprivations of liberty had been authorised with conditions, these were met.

People's nutrition and hydration needs were met. Food was attractively presented and special dietary requirements were catered for. Where there were concerns about unplanned weight loss or swallowing difficulties, the appropriate action was taken to address these, including pursuing referrals to the relevant health professionals.

People were supported with their health needs and had access to the relevant health professionals, such as GPs and district nurses. Medicines were managed safely and people had their medicines as prescribed. People were protected against avoidable harm and the risk of abuse. The premises and equipment were clean and well maintained. Risks associated with the building were now robustly assessed and the necessary action taken to manage these. The systems relating to the use of the laundry were now safe and clean and soiled were kept separate, and the laundry was clean and tidy. Litter bins were now provided and used appropriately.

People's individual risks, such as risks of malnutrition, pressure sores and falling, were assessed and managed through their care plans. Accidents and incidents were monitored for any further action that was necessary to keep people safe, and for any trends that might suggest further changes were necessary. Staff were aware of their responsibilities in relation to safeguarding people against abuse. Staff were employed only after the necessary checks, including criminal records checks, had been undertaken to confirm they were suitable to work in a care setting.

The service now had a robust quality assurance and improvement system. People's feedback was sought about their care through annual quality assurance surveys. The registered manager also had regular informal contact with people and their visitors. People and their visitors told us they would feel able to raise concerns with the registered manager. Staff were supported through training and supervision to be able to work safely and effectively. They were able to give their views through supervision and staff meetings, as well as through informal contact with the registered manager.

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.

Staff were deployed effectively to ensure people received care in a timely manner and were only recruited and employed after appropriate checks were completed.

People felt safe with staff, who took measures to assess risk to people and put plans in place to keep people safe.

Medication was stored appropriately and dispensed in a timely manner when people required it. Medication practices were regularly reviewed.

Infection control measures were now effectively used and maintained, ensuring that people's wellbeing was promoted.

Is the service effective?

Good

The service was effective.

Staff received an induction when they came to work at the service. Staff attended various training courses to support them to deliver care and fulfil their role.

People's rights were protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's food choices were responded to and there was adequate diet and nutrition available.

People had access to healthcare professionals when they needed to see them.

Is the service caring?

Good

The service was caring.

Staff knew people well and what their preferred routines were.

Staff showed compassion towards people.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans were individualised to meet people's needs.

There were varied activities to support people's social and wellbeing needs.

Complaints and concerns were responded to and thoroughly investigated in a timely manner.

Is the service well-led?

Good

The service was well-led.

There were a wide range of systems in place for assessing and monitoring the quality of service provided. These were used to identify and address potential risks to the health, safety and welfare of those who lived at the home.

There were systems in place to seek the views of people who used the service and others and to use their feedback to make improvements.

The home worked in partnership with other agencies, such as a variety of community professionals, who were involved in the care and treatment of the people at the home.

Lindsay House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 22 and 23 May 2017 and was unannounced. The inspection team consisted of the lead inspector for the service 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. Their area of experience was care and support for older people and people with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

During our inspection we spoke with 12 people who lived at the home, 11 relatives, the registered manager, deputy manager, and 10 care staff. We reviewed six care files, four staff recruitment files and their support records, audits and policies held at the service.

Good

Is the service safe?

Our findings

People and their visitors felt that they and their friends and relatives were safe living at the home. Their comments included: "I feel that [person] is well looked after and is in a safe place", and "She's in a safe place… We don't have to worry about her at all".

At our last inspection, we found that the registered person had not protected people against the risk of harm, because potential risks had not always been appropriately managed. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made.

Infection control policies were in place, and we found that flaking paint on the walls in various parts of the building had now been replaced. Clinical waste bins were in use, and emptied on a regular basis. Cleaning schedules were in place, and the records showed that they were maintained. Although the laundry room was small, it was found to be clean, and there were systems in place to ensure the separation of clean and soiled items, and systems in place to ensure clean clothes were able to be stored before being returned to people's rooms. Mops and buckets were found to be stored correctly, and there was a clear system in place for which mop to use when cleaning needed to be undertaken. The kitchen was found to be clean and tidy, and there were clear systems in place for the safe storage of food, and a cleaning scheduled that was maintained and followed by the catering staff.

We looked at six care files, and they were found to hold individualised risk assessments that were used to remove or reduce the possibility of accidents and incidents taking place, and in turn, support people's safety and welfare. Records covered care needs such as medicines, environmental and fire safety, nutrition, personal care, continence support and pressure area care.

The risk assessments were found to be detailed and tailored to each person's individual requirements. We spoke to a member of the care staff, who said, "As a change in someone's needs occurs or new risk is found, the senior carer staff or registered manager change records so that people are kept safe." This was confirmed when we looked at the care records, and through discussions with members of the staff team.

The service had good systems in place to monitor and manage accidents and incidents, and maintain people's safety and welfare. This included records of accidents, any resulting injuries and the actions staff completed to manage them. The service also had appropriate systems in place which were used to report any accidents or incidents to external agencies such as the CQC or the Local Authority Safeguarding team.

At the last inspection, we found that the registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to protect the safety of those who lived at the home. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection, we found that improvements had been made, and that Lindsay House had sufficient staffing levels to meet people's assessed needs, and this was supported through information held within the staffing rota. Staff were seen to respond to people's needs in a timely

manner. People at the home said that the staff did not rush them when providing personal care and support. Staff were deployed in different areas of service delivery such as catering, caring duties, cleaning duties and laundry duties. Staff were clear about their roles, and these were monitored by the registered manager to ensure that people were not left unsupervised, and their requests for support were not ignored. Visitors to the home said that there were always staff available, and when asked, did not indicate or suggest that staff were no deployed effectively, and always responded to their relative's needs and requests in a timely and appropriate manner.

Information held with the training and personnel records, showed that the staff team had a variety of skills and experience that they used to provide care and support to people at the home. The service had a clear policy and procedure in place for the safe recruitment of staff to the home. We found that new starters were required to complete an application form, and supply information about their past and present employment, qualifications and training, skills and abilities, referees, and declare if they had any convictions. Where applicants did not have a full employment history, any gaps or anomalies were discussed with individuals, and checks made to confirm any information supplied. Following an interview process, potential new staff undertook a criminal record checks obtained from the Disclosure and Barring Service (DBS). The registered provider had a system for seeking employment references.

The provider ensured staff received training to underpin their roles and responsibilities in protecting people from harm. Staff had a good awareness of safeguarding principles and where to report any concerns. Following any safeguarding incidents, we found the registered manager met with staff to debrief and explore system improvement and lessons learnt.

Peoples' medicines were managed and administered safely. Medicines were stored securely and recording systems ensured all medicines in stock could be accounted for. A computerised recording system was in place. Stocks of medicines were checked daily and monthly against the medicines records. Regular tablets and liquids were provided in boxes labelled by the pharmacy and bar-coded for use with the electronic system, with clear instructions to aid staff in administering medicines correctly at the right time. A photograph of each person was clearly displayed on the electronic device with the required information such as allergies. There was a facility to print off each person's medicines administration records (MAR) for use when supplying information to outside agencies, such as when people were admitted to hospital.

The deputy manager said, "Every transaction that relates to medication is logged on the system, along with staff codes. In this way a full audit trail is available on demand and information can be used to evidence which medication has been given, to whom, and by whom." The registered manager added, "There are a range of reports available, and this data can be accessed on a daily basis. I get a report at the end of every day about the medication and it alerts me to errors and out of stock items. If errors arise, I have the ability to identify staff training needs and areas of practice that need to be addressed. Senior management also receive these reports via email, and so are alerted to any problems." Information held with the medicines audits confirmed that daily reports were produced, and the information was detailed and straightforward to use.

We looked at records relating to environmental and equipment safety, and spoke to staff about how they and the service responded to emergencies or untoward events. We found that the fire alarm system was correctly tested in line with current best practice, and that staff were aware of how to respond in the event of either finding a fire, and/or hearing the alarm. People living at the home also were found to be aware of how respond in the event of fire. Care files contained up to date information on how to evacuate people in the event of a fire, and the staff we spoke with were clear about this, and were able to explain the process in detail.

There was a system in place for assessing, recording and responding to environmental risks. People were protected against hazards such as slips, trips and falls and other environmental hazards. Risk assessments were kept under review for hazards in the premises and there were plans in place to manage these. The systems relating to the use of the laundry were now safe, and clean and soiled were kept separate, and the laundry was clean and tidy. Litter bins were now provided and used appropriately.

The registered manager explained, "There are items of equipment that are under contact from other service providers, and they visit to undertake safety checks as and when required." Current safety certification was in place. This included: gas, electrical wiring and appliances, freedom of the water supply from Legionella bacteria, fire fighting and detection equipment, the lift and hoists.

Good

Is the service effective?

Our findings

People and their visitors spoke positively about their life at the home and told us staff were skilled to meet their needs. Comments included: "I like it here very much", "The carers are really good", and "It's a very good home; staff are very good to me".

At our last inspection, we made recommended that the management of mealtimes be improved in order to mealtimes a more fulfilling dining experience. At this inspection we found that improvements had been made. We observed people for enjoying their lunch and found there were menus available to show what options were available. We observed two individuals did not want what they were given, so staff asked what they would like instead. They returned immediately after their chosen meal was prepared. We observed people were smiling and relaxed throughout lunch. People living at the home told us that there was always a good choice of food, and that it was "tasty."

Care records we looked at held detailed documentation in relation to each person's nutritional needs. This included up-to-date nutritional risk assessments and control measures to minimise the risk of malnutrition. Where additional, associated risks could potentially occur, such as choking risks or medical conditions, the management team implemented further, separate processes.

We found the chef had maintained the kitchen to a high standard and had all required documentation in place and up-to-date. We looked to see what processes were in place to make sure people did not experience poor nutrition and hydration. We found that the staff were involved in ongoing assessment, planning and monitoring of nutritional and hydration needs and intake. We saw that if required, people were offered support and were enabled to eat and drink when necessary.

Staff confirmed they had the training they needed when they started working at the home, and were supported to refresh their training. Information contained within the staff training and personnel files showed that the staff team had received training in subjects such as food hygiene, safeguarding, the Mental Capacity Act, movement and handling, environmental and fire safety, communication and medication. The registered manager explained that Akari Care was in discussions with a new learning and training provider who would provide the staff with a new comprehensive training plan. She added that these discussions were ongoing at the time of the inspection, and that she would inform the CQC of the details, once the appropriate arrangements were in place.

The registered manager had systems in place to check staff learning and training through competency testing and supervision. One staff member told us that supervision was a one-to-one support meeting between the individual staff member and a senior member of the care or management team, and was used to review their role and responsibilities. Information held with the individual staff supervision records confirmed this, showed that supervision sessions and appraisals for staff members had been completed regularly and consistently. New employees were issued with a range of information when they first started to work at the home, including job descriptions and terms and conditions of employment, and were found to complete an individualised induction programme.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Mental Capacity Act 2005 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had identified through an appropriate assessment process, that there were some people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. The management team knew about the condition on a person's DoLS authorisation and took steps to address this.

We noted that staff obtained verbal consent from people when supporting them with tasks such as helping them to and from a chair, or supporting them with their meals. Other forms of consent included the signing of care plans by people who lived at the home, and if people were found to be unable to give consent following a mental capacity assessment, then best interests meetings took place.

We looked to see if people had access to, or used the services of external healthcare professionals. We found information within people's individual care plan records that if required, senior care staff and/or the registered manager arranged healthcare appointments on behalf of people, if people's health conditions or behaviours caused them concern, or if people requested it. One person at the home said that they were able to make their own appointments, and would tell the staff when an appointment was made. The staff we spoke with understood when to seek professional advice and support so people's health and welfare was maintained.

We found that people's weight was monitored, and any person who showed a significant weight loss would be referred to their GP for initial assessment and advice, and the catering staff would be informed of any changes that were needed in relation to the dietary needs. We noted that, when required, people also saw specialist health practitioners and others such as dieticians and opticians. These arrangements helped to ensure people's wellbeing was monitored and they were supported to remain healthy.

At our previous inspection we recommended that improvements be made to the electrical points available to people in the hairdressing salon, and that toilet roll holders should be made available in all toilets. We found at this inspection that toilet roll holders were now available and in use, and that there was no need for electrical points to be added to the hair salon as they were not needed. Electrical equipment was not used in this area of the building.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the caring attitude of the staff, and told us visitors were welcomed. Comments included: "Visitors are welcome at this home and encouraged", "Visitors are encouraged – I could visit any time", "I don't think I've come across anyone who wasn't helpful", "Everyone's been very kind and polite".

The registered manager explained that that staffing levels were linked to meeting people's assessed needs, and that staff had time to get to know the people they cared. She added that this, "enables them to build up good relationships." The atmosphere in the home was calm and relaxed. We saw that the interactions between staff and people living in the home demonstrated genuine care and concern. One visiting relative said, "The staff always show concern to the people living here: they are very attentive to my [relative], and listen to what they have to say, and respond accordingly." Another relative said, "The staff are very good and very caring. They have a laugh and a joke with people from time to time, and give reassurance and attention when needed. My [relative] can sometimes get a little down, and the staff are very kind in helping them cheer up."

We saw that people's care records were written in a positive, person centred way and included information about the aspects of daily living that they could carry out themselves as well as detailing the level of support they required when making decisions. This helped people to maintain their skills and independence. Care records showed that care planning was centred on people's individual views and preferences. People and their families were encouraged to talk with staff about the person's life.

Staff were seen to spend time with people, providing opportunities for them to express themselves. We saw people talking about the news, and staff asking people their opinions about events and stories they had seen on the TV. People were given the information and explanations they needed, at the time they needed them. We saw staff talking with people about what was happening or had just happened, such as when they were taking someone to choose some clothing, or when it was time for lunch.

The staff took appropriate actions to maintain people's privacy and dignity. We saw that people were asked in a discreet way if they wanted to go to the toilet and the staff made sure that the doors to toilets and bedrooms were closed when people were receiving care to protect their dignity. The staff we spoke with confirmed that they had received training in privacy and dignity, and this was confirmed through training information held in people's training files. A visiting relative said, "The staff see people as individuals, not just as a group of people who need to be cared for. Each person has to be approached or encouraged in a different way because they are different people, and the staff are very good at doing this." Information held within the care plans we looked at showed that information about people's religious belief or non-belief had been recorded, and staff understand the need to respect these beliefs.

Staff has access to a variety of information in the office that helped them to support people's individual needs. This included people's rights, equality and diversity, choice, consent as well as information on advocacy services available for people. Advocacy services ensure people who are unable to make decisions

and have no relatives receive external support to make these decisions.

The registered manager said that the home could, and had supported people at the end of their life. This involved finding out what people's wishes were regarding end of life care and support, and "adjusting the care and support to meet people's changing needs, and make links with palliative care professionals as and when needed." We found that the care records contained information about the care people would like to receive at the end of their lives, and who they would like to be involved in their care. Staff we spoke with said that they had supported people at the end of their life, but added that "we are very aware that there may be times when we cannot meet people's needs, due to illness or the need for more intensive healthcare, and so there will be times when people can't stay at home, and sadly, they may need to move to alternative accommodation such as a nursing home, or the hospital." The registered manager said that the home had good links with external healthcare professionals and end of life care professionals, and when needed, these were able to offer advice and support to the home, and people living at the home.

Good

Is the service responsive?

Our findings

At our previous inspection, we found that the registered person had not protected people against the risk of unsafe care or treatment, because records provided some conflicting information and areas of potential health risks were not always well recorded. This was in breach of regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that improvements had been made.

We looked to see if people's care plans were clear, up to date and based on their assessed needs. The staff we spoke with said that the senior carer staff were involved in putting together care plans, and added that they were able to have input into the plans. One said, "When people's needs change or if their behaviours change, then we explain this to the senior care staff, and changes are made to the care plans. We get enough time to read the care plans and update them when needed." One newly recruited staff member said, "I was given time to read the care plans, and ask questions about individual's care needs before I started working with them. The plans are clear and easy to follow."

We looked at six care plans, and found they were written from the individual's perspective. Staff built care plans around initial and ongoing assessment, developed from a variety of sources. This included observations of people's normal routines, as well as discussions with them, their families and other healthcare professionals involved. They contained information about preferences for care support, and described how people communicated their needs. The plans were complemented by daily communication records which demonstrated the levels of engagement and support both people needed and how this was delivered. We found evidence to show that the service had involved people in the assessment of their own care needs which enabled them to make choices about the support they needed.

Care plans viewed were individualised and detailed with people's preferences, such as sleeping arrangements, their backgrounds, likes and dislikes and behaviours. These care files also included specific individual information to ensure medical needs were responded to in a timely way. Care plans recorded people's individual behaviours and habits, and provided information about their history. This meant that staff had knowledge of the person as an individual and could easily relate to them. Care plan associated assessments were reviewed monthly or more frequently by the registered manager if needed to ensure they reflected people's changing needs.

Where healthcare professionals provided advice about people's care, this was incorporated into people's care plans and risk assessments. For example, one person had been seen by the speech and language therapist and a pureed diet had been recommended. Within the person's care file there was clear guidance to staff of how to manage nutrition and actions to take if food was declined or the person experienced choking. Staff at the home said that they were kept up to date regarding people's needs. Staff handover meetings took place to ensure staff had accurate and up-to-date information.

At the last inspection we recommended that the provision of activities be reviewed, and a choice of activities be provided, in accordance with their individual preferences. At this inspection we found that improvements

had been made. There was a varied range of programmed activities on offer at the home. These comprised of chair bound physical exercise, board games, team games, crafts, bingo and music, and trips out. The programme was displayed in the home to help people choose what they wished to participate in. People confirmed they were consulted on the activities and outings taking place and it was their choice if they participated or didn't participate. People's spiritual needs were acknowledged and provided for. There were links with local churches and church ministers visited the home at various times.

The provider had arrangements to manage complaints and concerns and carried out their duty of candour with a transparent approach. The registered manager told us they when they received complaints or concerns, then these were recorded, looked into and responded to accordingly. We found information was provided for people about how to make a complaint if they chose to. Details explained response timescales and information about how their complaint would be dealt with. People we spoke with were aware of who to speak with if they wanted to raise any concerns. One relative said, "If I have a problem I just tell them [the staff], and they deal with it. They are very good." The registered manager told us they preferred to deal with people's concerns as and when they arose. We checked to see if these concerns were logged by the service, and found that they were, and the actions taken by the service to resolve the concerns were also recorded.

Good

Is the service well-led?

Our findings

One visiting relative said, "The home puts people who need care and support at the heart of the service. The manager and staff are open, visible and approachable, and always willing to listen if we have problems or concerns."

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection, we found that the registered person had not ensured systems were in place for effectively assessing, monitoring and improving the quality and safety of the services provided, including the risks relating to the health, safety and welfare of service users. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that measures had been put in place to ensure improvements were made. Infection control measures such as the provision of appropriate litter and clinical waste bins were now in use, the laundry was clean and tidy, risk assessments were linked to people's assessed and ongoing needs and the registered manager had effective quality assurance and monitoring systems in place.

The registered manager gathered people's views on the service through their daily interactions with them. In addition they held meetings with relatives and people to discuss the running of the service and used questionnaires to gather feedback. The management team analysed feedback from all surveys to check the quality of service provision. Areas covered included food, environment, infection control, safety and security, care and staff approach. We saw feedback from professionals was actively encouraged and reviewed as part of the home's ongoing development. If issues were raised, then the registered manager responded accordingly. For example, when issues were raised regarding the quality of the food, appropriate measures were put in place to make improvements, and create more choices on the menu.

The registered manager had a number of quality monitoring systems in place to continually review and improve the quality of the service provided to people. They carried out regular audits on health and safety, infection control and care records this information was used as appropriate to continually improve the care people received. The registered manager frequently completed separate care plan and risk assessment matrices. These ensured people's risk management and care provision were continuously updated and met their needs to an effective level. There was a range of communication systems in place to keep staff up-to-date and maintain the highest level of care for people who lived at Lindsay House, this included handovers and associated records.

The home worked in partnership with other agencies, such as a variety of community professionals, who were involved in the care and treatment of the people at the home. District nurses and social workers visited the home as and when required, and there were good communication systems between these professionals and the home. Professionals added details to people's care records, and staff maintained good records so

that professionals received a clear chronological understanding of people's needs and healthcare concerns.

The management team additionally completed weekly checks for all risk areas. This included call bells, health and safety, window safety and restrictors, water temperatures and fire management systems. We also found the home's safety requirements were up-to-date, monitored and recorded. These included environmental, fire, water, gas and electrical safety. Records we saw evidenced audits were reviewed, discussed and then new systems were implemented to replace or enhance the old procedures. This gave the provider good oversight of care provision, service quality and everyone's wellbeing.