Elder Homes Leeds LLP

The Links Care Centre

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
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**

Overall summary

This inspection took place on 28 September 2015 and 2 October 2015 and was unannounced.

The Links Care Centre is a purpose built home which can accommodate up to 85 people on two floors. All the bedrooms have en-suite facilities and communal areas are provided throughout the home. It is located close to Bradford city centre and is easily accessible by public transport. The service specialises in the care of people with mental health needs.

The service did not have a registered manager. There had been no registered manager in place since July 2015. 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 in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was enough staff to meet people's needs. Most people using the service told us they were well cared for and felt safe with the staff who provided their care and support.

We saw the service was recruiting more activity staff, but at the time of inspection activities were limited for most people who lived at the service.

Summary of findings

Medicines records were accurate, complete and the service's arrangements for the management of medicines protected people. People's medicines were stored securely.

Accidents and incidents at the home were reviewed and monitored regularly. This was to identify possible trends and to prevent reoccurrences.

Staff recruitment practices at the home ensured that appropriate recruitment checks were carried out to determine the suitability of individuals to work with vulnerable adults. Security checks had been made with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

People received care from staff who were provided with effective training and support to ensure they had the necessary skills and knowledge to meet their needs effectively.

Staff told us, and records we examined showed that regular supervisions were being carried out. All new staff received appropriate induction training and were supported in their professional development.

There were effective processes in place to help ensure people were protected from the risk of abuse and staff were aware of safeguarding adults procedures. Staff understood what abuse was and how to report it if required. A whistleblowing policy was available that enabled staff to report any risks or concerns about practice in confidence with the organisation.

Staff were attentive when assisting people and people told us they usually responded promptly and kindly to requests for help. Most people living at the service had appropriate risk assessments in place to ensure risks were evaluated and that appropriate care and support was supplied.

Most people told us that staff treated them well and mostly we observed kind and caring interactions between staff and people using the service. Staff were patient, unhurried and took time to explain things to people most of the time. However, some people who used the service told us there were times when their experience of care and support fell short of the required standard. This included times when staff were busy and people felt rushed. We were also told the food quality varied dependent on which staff were on duty.

Staff acted in a professional and friendly manner and treated people with dignity and respect. We observed staff supporting people and promoting their dignity and independence wherever possible.

Detailed procedures and information was available for staff in the event of an emergency at the service.

The provider had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy and further detailed information was available for staff. The requirements of MCA were followed and DoLS were appropriately applied for to make sure people were not restricted unnecessarily, unless it was in their best interests and safe.

People were supported to make sure they had enough to eat and drink, to have access to healthcare services and to receive on-going healthcare support. Relatives we spoke with told us communication with the service was good.

People were involved in their care and how they were supported. Care records confirmed the involvement of people in care planning and reviews. Advocacy information was accessible to people and their relatives.

Surveys were undertaken to seek and act on feedback from people and their relatives in order to improve the service.

Most care records were regularly reviewed and evaluated. They contained up to date and accurate information on people's needs and risks associated with their care. Health and social care professionals and relatives were involved in the review process where applicable.

A complaints policy and procedure was in place. People told us that they felt able to raise any issues or concerns. Complaints received by the service were dealt with effectively and the service had recently received a number of compliments.

Summary of findings

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.

Medicines records were accurate, complete and the service's arrangements for the management of medicine protected people. People's medicines were stored securely.

Staff recruitment practices at the home ensured that appropriate recruitment checks were carried out to determine the suitability of individuals to work with vulnerable adults.

There were effective processes in place to help ensure people were protected from the risk of abuse and staff were aware of safeguarding adults procedures.

Is the service effective?

Requires improvement

The service was not always effective.

We asked people if they were listened to or if they were able to consent to things. Feedback was mixed with positive and negative comments.

Staff told us, and records examined showed that regular supervisions were being carried out. All new staff received appropriate induction training and were supported in their professional development.

People were supported to choose their food two days in advance. Staff supported people to make sure they had enough to eat and drink. People were undecided about the food with a mix of responses to our questions.

Is the service caring?

Requires improvement

The service was not always caring.

Some people told us that staff treated them well and we observed kind and caring interactions between staff and people using the service. Some people told us staff were not always prompt to reply to people's requests.

Staff acted in a professional and friendly manner and treated people with dignity and respect. Staff supported people and were promoting their dignity wherever possible.

Is the service responsive?

Requires improvement

The service was not always responsive.

Most care records were regularly reviewed and evaluated. They contained up to date and accurate information on people's needs and risks associated with their care. Health and social care professionals were involved in the review process where applicable.

Summary of findings

A complaints policy and procedure was in place. People and their relatives felt able to raise any issues or concerns. Complaints received by the service were dealt with effectively and the service had recently received a number of compliments.

Activities did not happen as much as planned due to staff shortages. People told us activities were offered but there was not much choice.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service had no registered manager in place.

The service had a manager who spoke positively and enthusiastically about their role. They told us they were keen to develop their role and help ensure people continually received good quality care and support.

We identified areas of improvement in the service that robust audit systems should have identified.

The Links Care Centre

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 28 September 2015 and 2 October 2015 and was unannounced.

The inspection team consisted of four inspectors and one 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. The expert by experience had experience with mental health services.

We looked at seven people's care records. We spoke with 15 people that used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing care and speaking with the manager and staff. We asked for feedback from the City of Bradford Adult Protection Unit. We looked at care plan documentation as well as documentation relating to the management of the service such as training records, policies and procedures.

On this occasion we did not ask the provider to complete 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. Before the inspection, we reviewed all the information held about the provider.

Good

Is the service safe?

Our findings

We looked at how staff were recruited. Appropriate checks had been undertaken before staff began working at the service. We looked at six staff files. Staff files included copies of applications forms, at least two references and personal identification. New staff had a formal interview, followed by an interview in the service to meet the people they could be working for. Disclosure and Barring Service (DBS) checks had also been carried out on new staff prior to working at the service. DBS checks are for the service to review a staff member's criminal history or if they had been placed on a list for people who are barred from working with vulnerable adults. This assisted the service to make safer decisions about the recruitment of staff. We found the appropriate checks were in place to ensure prospective staff were suitable to work with vulnerable people.

Staff explained to us it was mandatory for them to complete training on a number of required subjects before commencing work. These courses included introduction to dementia, medicine administration, Mental Capacity Act and Deprivation of Liberty Safeguards, safeguarding adults, health and safety, food hygiene and managing challenging behaviour.

We spoke with nine people that used the service. Five people told us 'yes' that they felt safe. One person said, "Ever since I've come here I've been happy." Four people that used the service had mixed feelings about feeling safe. One person said they, "Sometimes" felt safe and that the environment and the other residents made them feel anxious. For example they told us one person who used the service could be loud and aggressive at times.

People we spoke had mixed views about staffing levels. One person told us, "The staff here are always here and ready to help us with things on a daily basis." Another person said, "There are always enough staff during the day and the night." A visitor told us, "All staff are lovely always nice and have time for you." Another person said, "There is enough staff, but we could do with some more" and one more person told us, "Yes and no. I would like more staff."

We asked how staffing levels were worked out to ensure appropriate levels of staff to keep people safe. The manager told us there was no specific tool used but staffing levels were reviewed on a six monthly basis by the area manager. They told us they looked at the number of people that used the service and the overall needs of people on each unit. We saw that agency staff were used on average about twice a month to help cover sickness.

We noted that there were sufficient levels of staff planned in to provide a safe level of support to people. We looked at staffing rotas for the week of the inspection and the previous two weeks and saw staffing levels reflected what we were told by the manager. We saw when staff were off sick with late notice, staff were moved around from the different units to provide more appropriate support across the service. However some staff told us when they rang in sick it left a lot of work for the other staff that were working. The majority of staff we spoke with told us they believed staffing levels were appropriate when there was no sickness. One staff member told us, "If we put additional staff on and there was no sickness, they would not be required."

People living at the home had appropriate risk assessments in place to ensure risks were identified and reduced. For example, care records we reviewed identified risks in relation to mobility, safe moving and handling and falls risks. We saw that where external professionals had been involved in supporting people, their assessments and advice about safety had been incorporated into the risk assessments.

People received their medicines in a safe way. We looked at how medicines were managed in the service. Medicines were stored securely. There was an appropriate system for the recording of medicines disposal'. We checked a sample of medicines in stock against the Medication Administration Records (MAR) and found these were correct. We observed a staff member administering medicines and they signed the MAR after the medicines had been administered. This helped reduce the risk of errors and our findings indicated that people had been administered their medicines as prescribed. People had an individual folder for medicines administration. These had their photographs on the front and a chart where name, date of birth and allergies were highlighted. The file also contained a copy of authorised signatories, and confirmation that correct medicines had been administered.

Care records recorded how people liked to take their medicines. For example one person's care record stated 'I like to take my medicine from the pot independently with

Good

Is the service safe?

water or juice. It also stated that 'I need reminding to take two puffs of my inhaler'. There was also an easy read file with pictures and diagrams of all the medicines used in the unit which had been put together by staff to make it easier to explain to people what medicines they were prescribed. We saw people's medicines were subject to monthly reviews by their GP. A risk assessment recorded people's agreement and wishes around support with medicines. As and when required medicine (PRN) was monitored by staff and documents were in place that supported this practice. For example we saw a PRN protocol sheet for staff to follow. We saw a file which contained evidence of policies and procedures based on The National Institute for Health and Care Excellence (NICE) guidelines.

Staff training records confirmed all staff who managed medicines had received recent appropriate training. We observed staff administered medicines to people and noted that the medicines trolley was clean tidy, locked and secured.

We saw that where safeguarding incidents were identified, these were reported and acted on appropriately and recorded for reference. A safeguarding policy was available for staff to refer to and this had been updated and reviewed in May 2014. This included the procedure for making alerts and referrals along with contact details for the local authority safeguarding adults team. Staff we spoke with had a good understanding of safeguarding and knew how to report concerns. They were able to describe various types of abuse and were aware of potential warning signs. Staff told us if they had any concerns they would report matters directly to the manager. All of the staff we spoke with said they did not have any concerns about the care provided or the safety of the people living in the home. They told us they felt able to raise concerns and felt the manager would deal with their concerns immediately and effectively.

The manager told us accidents and incidents were reviewed and monitored regularly. This was to identify possible trends and to prevent reoccurrences. We were told where appropriate, care plans and risk assessments would be reviewed to ensure people were kept safe. We saw the service kept an accident and critical incident file which was completed and regularly reviewed by the manager. This included incidents which had resulted in safeguarding adult and Care Quality Commission (CQC) referrals.

Personal emergency evacuation plans (PEEPs), describing how people should be evacuated from the building in the event of an emergency were in place for most people at the home, along with a fire evacuation plan of the building. The manager told us, and records confirmed that the provider operated an out of hours contact facility where staff were able to contact a duty manager for advice and support in the case of emergencies. Records confirmed regular fire equipment tests and procedure testing was completed.

Requires improvement

Is the service effective?

Our findings

Most people and their relatives were complimentary about the staff employed by the service and told us they enjoyed spending time with staff and they were well cared for. One person told us, “They (name of staff) always has time for you.” A relative told us, “The staff always make sure my husband is washed and showered, he is always clean shaven” and “They always discuss any problems with me and would contact me if there were any changes to his care.” Other relative’s comments included, “It’s family orientated everyone is involved in the care of people.”

All new staff attended a robust induction course, followed by a period of shadowing an experienced and established colleague, before working alone. Staff we spoke with confirmed their induction program helped prepare them for their jobs and the working environment before being allowed to work alone. The manager told us staff then undertook a six month probationary period, during which their suitability to perform their role was regularly reviewed. Following a successful completion of their probationary period, staff were enrolled on a level two or three National Vocational Qualification and embarked on gaining adult health and social care qualifications. Staff we spoke with were all in agreement that the induction period and content allowed them to work effectively and safely with people who used the service. One staff member told us, “The training and support here is excellent.”

There was a completed programme of training for staff. We saw a wall chart with dates for staff members to attend training. Staff we spoke with confirmed they had received the training they needed. We saw and staff told us they had undertaken mandatory safe working practices training. For example, equality, diversity and dignity, safeguarding adults, fire safety, food hygiene, moving and assisting, emergency first aid and infection control. Training records and certificates examined confirmed that care staff received training that was specific to the needs of individuals they cared for.

During our inspection staff told us, and records confirmed that one to one meetings, known as supervisions, as well as annual appraisals were conducted. Supervision sessions were used, amongst other methods to check staff progress and provide guidance. Appraisals provided a formal way for staff and their line manager to talk about performance issues, raise concerns, or ask for additional training. One care assistant told us, “I get the support to do my job.”

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 manager was able to demonstrate their knowledge and understanding of the MCA and awareness of the legal changes widening the scope of DoLS. We saw the provider had a MCA and DoLS policy and MCA / DoLS information was available at the service. The manager told us, and records confirmed that DoLS applications had been made to the local authority and had been authorised within the last 12 months. Care records viewed showed evidence that mental capacity assessments were being completed consistently and were regularly reviewed.

People were supported to keep up to date with regular healthcare appointments, such as GP’s, dentists, nurses, specialist consultants and other primary care services. We asked six people if they had their health care needs met and they told us they did. Comments included: “Yes, everything's supplied for you” and, “I see the dentist as I have a problem with one of my teeth.”

Throughout the visit we saw people were offered choices and asked for their permission. For example, one person was asked if they would prefer a cold drink instead of a cup of tea. At lunch time, staff asked people if they had finished their meals, before taking plates away and asked one person if they would like their drink transferring to a smaller cup so they could drink more easily. We saw staff were pleasant and gave people adequate time to consider and

Requires improvement

Is the service effective?

discuss their choices. We asked nine people of their experience of being offered choice and they told us yes or had mixed feelings when asked if they had choice and was their choice listened too. Four out of the nine people we spoke with told us they did not always get given choice. Comments included, “Not all of them (staff).” Another person said, “Sometimes yes, sometimes no” and another told us, “If there's time yes. Not enough time with the staff.”

We spent time observing the lunch time experience at the service. We saw people were supported to eat and drink sufficient amounts to meet their needs. Meals were well presented and there was an enjoyable and relaxed atmosphere in the dining area. We observed staff consistently supported people, whilst promoting their independence. Where staff provided support for people to eat or drink, we saw this was done in a personalised and dignified way, with staff providing encouragement to people throughout the meal. We noted a selection of snacks and refreshments were available between main meals. The service also had its own ‘sports bar’ where people could go for snacks and meals.

Staff told us people were asked two days prior to each meal what they would like to eat and their choice was recorded. On the day, if a person had changed their mind then alternatives could be made for people. People views were divided about the quality of the food. Some people told us it was nice and they enjoyed it, while others said they did not enjoy the food. Staff acknowledged that the food quality and appeal could vary from day to day. They told us this could depend on who was cooking and what was being cooked.

Those people, who required certain food due to their needs or faith, were offered alternative choice in line with their wishes. Food stocks in the service were plentiful. We looked at the menus and found these had not been reviewed in over 12 months. We saw drinks stations around the service with a regular service of staff offering drinks to people if they required it.

The service was purpose built and had some areas of new decoration. Dining areas appeared to look fresh and vibrant where corridors looked dated with non-descript colours and decoration. We noted there were two passenger lifts between floors and there was good wheelchair access around the building. Some people’s rooms were decorated to their personal tastes. The home had a secure and enclosed patio area and a designated smoking area. We saw some of the furniture in the patio areas was damaged and missing wood sections from the table and chairs.

Requires improvement

Is the service caring?

Our findings

Due to their health care conditions, some people were unable to tell us about their experiences of living in the service. However, people we spoke with were positive or were undecided about the care and support they received. One person told us staff were, “Polite and helpful.” Another person said, “Caring, considerate, well meaning, and very punctual.” Other people that used the service said, “They could give you a little more attention,” and, “They can have their off days, but when they're on their good days they can be a right laugh. If you say hello and they don't respond then you know their having an off day. At times it feels like they’re badgering and rushing to get things done. That is how mistakes are made.”

During the first day of our inspection care staff were observed acting in a professional and friendly manner, treating people with dignity and respect. Staff we spoke with had a good understanding of the importance of treating people with dignity and respect. They gave us practical examples of how they delivered care and how they achieved this. For example, making sure people were dressed according to their choice, knocking on people’s room doors and waiting for a response before entering and offering choices. Eight out of the nine people we asked if they felt their dignity was respected told us it was. One person told us, “Staff don’t always knock on my door” but agreed mostly its respected. Another person told us, “Staff always respect my privacy and I can be left alone if I wish.”

Throughout our inspection we saw staff were attentive most of the time when assisting people and found that they responded promptly and kindly to requests for help. However on one occasion we saw a person sat down for five minutes in a busy corridor waiting to be supported to another room, and staff continually walked past them without talking to them. We also saw most staff would pay attention to people when they were spoken to and listened carefully to what they had to say. People we spoke with were not always positive when asked if their requests were responded to promptly. One person told us, “That can depend on what they've got on at that particular time. There are 14 people on this unit. The staff can be in one room, you can be wanting something. It's those times when they can't come straight away because of an emergency.” For the most part we observed staff interacted with people well and we saw staff taking the time to stop and chat with people, listening carefully to what they had to say and showing a genuine interest.

People we spoke with told us, and records confirmed they were involved in their care and support that they received. Care records confirmed the involvement of relatives when appropriate in care planning and reviews. This helped to ensure that important information was being communicated effectively and care was planned to meet people’s needs and preferences.

Most of the people that used the service that we spoke with confirmed they were well cared for. Most people told us they were given sufficient time that they required without feeling rushed. Comments included, “98% of the time they do” and, “They're busy aren't they” and, “Sometimes.” We asked people if they felt they had the confidence to speak their views and they would be listened to. Most people said yes they would. Others said not for various reasons. Comments included, “No, I’m shy” and another person said, “The staff can’t give me advice on subjects I need (religion).” Generally people had told us they were supported with aspects that surrounded their faith.

Requires improvement

Is the service responsive?

Our findings

Some people who lived at the service were able to tell us about their experiences. Four people told us they were able to sit and talked with staff about what was important to them. Another four people told us staff did not always have the time. For example one person told us they chatted with staff, “If they’ve got time” and another person said, “Not all the time, no.” We also asked people if they were consulted about their views and opinions. Four people said yes they had been asked and involved. Another four people told us they had not been asked. These comments included, “I’m not bothered” and, “I don’t think I have ever been asked.”

All the people we spoke with told us they were aware of the complaints procedure and how to make a complaint. We saw the service had a complaints policy and procedure. This detailed the process that should be followed and indicated that complaints received should be documented, investigated and responded to within a set timescale. All the people we spoke with told us they could confidently raise issues and all said they would approach staff or the manager if they wanted to make a complaint. One person told us, “I would talk to [staff member’s name]. If they’re not available I would go to the manager or one of the male nurses.” Another person told us, “Any member of staff I would talk to” and a further person told us, “I would speak with the manager.”

We examined the complaints records for the service and saw five complaints had been received during 2015. Records confirmed these five complaints had been documented, investigated and resolved, where possible to the satisfaction of the complainant. There was evidence to confirm a response had been given to the complainant. The manager told us they regularly reviewed complaints received to identify emerging patterns and trends and to identify any potential risks. We found complaints had been dealt with in line with the provider’s policy. We saw one recorded compliment from a visiting professional.

People told us regular activities were sometimes organised throughout the home. The manager told us activities were currently arranged and co-ordinated by the activity coordinator. The service was in the process of recruiting two further activity coordinators which they showed us evidence for. This would raise staffing levels for activities from 40 hours per week to 120 hours per week. The manager also told us they were keen to improve the range and quality of activities, events and other leisure interests at the home. The service also benefitted from a room centred in the middle of the service from which activities could be based from. People’s feelings were mixed about the range of activities available and how people were engaged and stimulated. People’s comments included, “Painting, no other activities” and another person said, “I tend to make my own activities. I go out quite a lot, go to the sports bar a lot. I've got my TV my Hi-Fi system. Nine times out of ten they'll plan it [activities] and it will go flat as a pancake” and a further person told us, “Pool and other activities. I don't do any actually.”

During our visit we saw people playing board games with staff. We saw activities advertised around the home included trips out to places of interest, excursions to local shops, arts and crafts and trips to religious centres. People told us they were fully supported with their religious beliefs. For example one person told us, “Yes, we went to Mass, loads of us.” And another person said, “I go to church in a taxi or I walk” and a further person told us, “I go to church every week. Went yesterday. Very much enjoyed it.” The manager told us people also enjoyed swimming and exercise at local leisure centres.

Six of the seven care records we examined contained details from pre-admission to present day. The records were stored correctly and the contents were clearly indexed. All records examined contained a pre-admission assessment and a comprehensive set of care plans that reflected people’s assessed needs. We noted nursing staff developed and maintained the records and updated the care plans on a monthly basis. A daily report record for each person was kept to allow for contemporaneous records of care.

Care records described the person’s needs, how their needs would be met and any potential risks associated with providing their care. We found care plans were regularly evaluated and GPs, nurses and other health and social care professionals were involved in the review process where applicable. Care record reviews and updates happened for most people on a regular basis. Most of the plans we looked at on the day of inspection had been reviewed in the past six months. People we spoke with said they had been involved in care planning and told us there was good communication within the home. They also said they felt fully informed about any changes or developments in their care and condition. One care plan we saw lacked care

Requires improvement

Is the service responsive?

plans for certain areas of this person's life. For example we saw no care plan for mobility, moving and handling, breathing and circulation and risk assessments had not been completed. We asked the manager about this person who agreed the plan should be up to date and that they would review this person's care records.

People told us they were supported and encouraged to maintain relationships with their families and friends who mattered to them. This meant they kept in regular contact with people and this reduced the risk of social isolation. One person told us they were supported to visit their relative every week and another person said, "My family are living in another County. I don't get to see them that often." Another person said, "No because I don't want to see them." Two further people told us they saw their families on a regular basis.

Requires improvement

Is the service well-led?

Our findings

The service did not have a registered manager. The service had been without a registered manager since July 2015. We spoke with the manager of the service who had not been asked to register with the Commission by the provider.

We found the service had submitted statutory notifications to the Care Quality Commission. Notifications are changes, events or incidents that the provider is legally obliged to send us within a required timescale. As part of the planning for this inspection, we reviewed notifications that had been sent to us. We found no further evidence of information that should have been submitted to The Commission.

We discussed checks the manager and senior management team conducted and completed to ensure people were receiving appropriate care and support. The manager told us, and records confirmed that monthly audits of the service were completed by the manager to ensure health and safety at the home was maintained. These checks included environmental areas within the home and the exterior of the building. Issues identified and actions required in the service reviews and audits were tracked through to completion. The person responsible for addressing the issue was identified and an agreed timescale for the action to be addressed was given. The audit was checked to confirm the areas identified had been rectified prior to the next audit occurring. We also saw audits on a monthly basis completed by the area manager to confirm findings and look for improvement. Senior management from the provider completed a quarterly inspection.

Health and safety trend analysis was completed by the manager and submitted to the provider's head of compliance. This included all resident and staff accidents and incidents, the number of RIDDOR (reporting of injuries, diseases and dangerous occurrences Regulations 1995) reports made where appropriate, CQC notifications, safeguarding adults referrals, complaints and compliments. Evidence of a mattress audit which identified any damaged mattress had been entered onto an improvement plan. Care plan audits were completed every three to six months depending on the needs of the person. These care plan audits identified areas for improvement which had been entered onto an action plans for any improvements.

We saw records were kept of equipment testing and these included fire alarms and firefighting equipment, electrical appliances, emergency lighting and the calibration of scales. Other equipment and systems were also subject to checks by independent companies or assessors. For example, records showed hoists, passenger lift servicing, gas and electrical checks, legionella risk assessments, fire safety systems servicing and checks were carried out at appropriate intervals. We noted that these were up to date, accurate and were completed regularly.

Records confirmed and staff we spoke with told us staff supervision meetings were held regularly. They said that they received supervision every two to three months and an annual appraisal. We were able to confirm this by looking at staff member's records of supervision and of recent staff members' appraisals. We were told this could vary depending on the support each staff member required. All the staff we spoke with told us they were sufficiently supported. We saw topics discussed in supervisions included improving communication, the importance of accurate documentation, staff recruitment, training and personal development. Staff told us they were able to 'speak up' at the meetings and they felt confident they were listened to and able to discuss important matters. Staff told us that the manager was approachable and open to suggestions for service improvement. One staff member told us, "The training and support here is excellent."

People we spoke with mostly told us there was a good, positive and friendly atmosphere at the service. One person told us, "I like walking around the home and going to the bar to speak with people." Another person said, "Some of the décor and seats need looking at but it's a nice place to be and I like it overall." People told us they thought the home was well managed. One person told us, "The management do a good job. I can speak with them if I need too." We observed that members of staff were positive and enthusiastic about their work. Staff told us that the manager was approachable and open to suggestions for service improvement.