Silverline Care Limited

Linson Court

Inspection report

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West Yorkshire
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 inspection took place on 7 November 2018 and was unannounced. We previously inspected the service on 4 and 6 September 2017 and we rated the service requires improvement. This was because the service did not always ensure good infection control practices, regular involvement of people and their relatives in the running of the home, and there was no sustained evidence of regular audits taking place.

During this inspection we identified the home had made improvements. The home was clean and in a good state of repair. Appropriate infection control practices were followed. The home had undertaken regular involvement of people and relatives in the running of the home. Regular audits were undertaken.

Linson Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Linson Court provides nursing care and support to people, some of whom are living with dementia. The home has a maximum occupancy of 40 people. On the day of our inspection there were 37 people living at the home.

The service had a registered manager in place. 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.

People told us they felt safe living at Linson Court. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and systems were in place to reduce the risk of employing staff who may not be suitable to work with vulnerable people. Sufficient numbers of staff were deployed to keep people safe and the home manager had gained approval for and implemented additional staffing resources.

Care plans contained individualised risk assessments and adequate information to ensure people's care and support was safe, however these had not been updated regularly. People had up to date personal emergency evacuation plans and fire risks were well-managed.

Premises were safely maintained and appropriate checks to ensure this were completed. A recent refurbishment of the lift had taken place to ensure this was safe.

Medicines administration records (MAR) were in place to monitor and manage the administration of medicines. This system was used safely and recorded consistently.

New staff received an induction to the home which included mandatory training and shadowing more experienced colleagues. Staff received ongoing training and a programme of regular supervisions and appraisals had been planned, however not all staff had received a regular supervision in the months prior to the inspection.

Mental capacity assessments were decision specific and people were deprived of their liberty lawfully. Staff were aware of how to promote independence.

People were offered a good choice of meals. Their nutritional risks were assessed and weight loss monitored and appropriate action taken when necessary.

People had good and timely access to external healthcare professionals.

People told us staff were caring and kind. Staff were knowledgeable about people and encouraged people to make choices about their daily lives and retain a level of independence. Staff were aware of the need to maintain people's privacy, dignity and confidentiality.

People's care plans were person-centred and detailed. Regular reviews of people's care had not taken place however the manager had implemented a programme of reviewing each and every care and support record. This had not been fully completed at the time of our inspection.

There was access to a range of activities, including inter-generational projects, and people received some one-to-one activity.

People were aware of how to complain and the registered manager responded and documented any concerns raised.

People were asked about their end of life care wishes and these were recorded. The registered manager and staff were knowledgeable about supporting people and their relatives at this time.

Staff were positive about the registered manager and the deputy manager. Staff meetings took place and staff were actively involved in these.

A range of audits were completed on a regular basis by senior staff, the registered manager and senior regional managers and areas of concern identified during these had actions identified and completed.

The registered manager compiled a monthly report which recorded a variety of information relating to the day to day running of the home. A senior manager regularly visited the home and audited the quality of the service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments lacked detail and not all care plans had been regularly reviewed.

People told us they felt safe living at the home and staff were knowledgeable about how to protect people from abuse.

People's medicines were administered by staff who had been trained and had their competence checked in line with best practice.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Is the service effective?

Good

The service was effective.

Consent to care and treatment was monitored and recorded.

People's had a good choice of food and drink and staff were knowledgeable about their likes and dislikes.

People had timely access to appropriate and external healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff treated people were treated with kindness, dignity and respect.

Diversity was embraced and people's cultural needs were met.

People's records were stored securely and their confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

Person-centred care assessments were completed before admission and the manager checked these to ensure the home could meet people's needs.

Concerns and complaints were recorded and monitored.

End of life wishes were discussed and people and families were supported to meet these wishes.

Is the service well-led?

Good

The service was well-led.

The service took steps to check the quality of the service, and had made improvements to how the home was run.

People and staff were encouraged to share their views.

Community links were evident and had recently been developed to be more representative of the local community and the community within the home.

Linson Court

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 site visit took place on 7 November 2018 and was unannounced. This meant the service did not know we were visiting. The inspection team comprised two adult social care inspectors. On 13 November 2018 we reviewed documents which had been sent to us by email, and spoke to staff and relatives over the telephone.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered manager is required to tell us about. We contacted commissioners of the service, the local authority safeguarding team and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with four people who lived at the home and five of their relatives or friends. We spoke with the registered manager, the deputy manager, an associate practitioner (who's role is to support the management of nursing and personal care and support), a nurse, a senior care assistant, three care assistants, an activity co-ordinator, a cook and a domestic. We looked around the building and saw the communal lounges, dining rooms and bathrooms. People showed us their bedrooms. We spent time observing care in the communal lounges and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records, which included three people's care files in detail, as well as looking at

aspects of three other people's care records. We also inspected four staff members' recruitment and supervision documents, staff training records and other records relating to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the service and one person replied, "Certainly". Another person said, "I like it here, I have never been so happy, staff are good if I buzz." However, another person told us, "If I rang they [staff] don't come quickly" and another person said, "Yes, I feel safe, some [staff] are very anti-social, all day they come in and go and don't say good morning."

Relatives comments included, "They [person] seem to be safe, no accidents", "They look after mum well", "I'm very happy with the care here", "No, never had any concerns" and "[Person's name] is looked after very well."

A staff member said, "Safe? Yes, [people] are well looked after."

People's were at risk because assessments were not always detailed and had not always been updated. The registered manager was aware of this and the senior management team in the home had commenced a programme of undertaking a full review of each person's care plans, although there were some still to be undertaken. Behaviour risk assessments were not detailed for one person. For example, the potential impact to other people living at the home had not been recorded. However we did not see evidence, from accident and incident records or people's daily notes, there had been any impact to people living at the home because of this. We looked at some of the reviewed care plans and found they showed all aspects of people's needs had been considered and recorded. This enabled staff to provide the right care and support to people.

People were at risk because in some instances mobility assessments were not individualised. For example, one assessment said the person needed full assistance with two staff members, however there were no details about how the transfer should be done and what equipment should be used. We brought this to the attention of the registered manager who said they were aware more detail was needed and this would be included during the wholescale reviews being undertaken by senior staff.

The safeguarding referral process was well managed. The registered manager used a system to record and monitor concerns. Staff had completed safeguarding adults training and were aware of their responsibilities in protecting people from abuse. Staff told us they were comfortable raising concerns and described the process of how to do so. A staff member confirmed, "Definitely feel comfortable going to the manager with any concerns."

A robust system was in place to evacuate people safely in the event of an emergency. The fire evacuation plan included a zone by zone breakdown of what action staff should take unique to each zone. People's personal evacuation plans (PEEPs) were up to date and contained accurate information to support their safe evacuation. A 'fire box' was updated every week and contained a copy of each person's PEEP, as well as other items which would be useful in an emergency, such as a mobile phone, a walkie-talkie, torch, glucose tablets, and bracelets to identify people.

During the inspection we found there were sufficient numbers of staff to meet people's needs. The registered manager reviewed people's needs on a regular basis and completed a dependency tool to assess staffing levels. Staffing rotas were produced in advance and the associate practitioner considered the staff skills mix for each shift. Staff were not rushed and the atmosphere was calm. A relative told us, "During the week it [staffing level] is OK, but during the weekend if seems less. They [staff] check [person] often." A staff member said, "Staffing is up and down, it goes with the number of [people living here]." The registered manager told us they were recruiting to vacancies and had implemented a new staffing rota system at the start of the week. This rota showed staffing was consistent throughout each shift. The registered manager told us this was in response to people's needs and to provide staff with more flexibility. Staff had received meetings to inform them about these changes.

There were some staffing vacancies within the home and the registered manager told us they used some agency staff to cover these vacancies. These agency staff received an induction before they started work. A person told us, "If it's a new [person] they fetch them in with someone that's supported me before, it's a good system."

Recruitment was undertaken safely. Staff files showed the service had checked to minimise the risk of employing people who were not suitable to work with vulnerable people. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Medicines were administered safely by trained and competent senior staff. Senior staff received annual training and their competency to administer medicines was reviewed every six months. A medicines administration record (MAR) for each person was completed. These were up-to-date and provided an accurate record of people's medicines, which corresponded to medicines held in stock. Some people received their medicines covertly and we found appropriate best interest decisions had been made to support this.

Some medicines were stored securely in people's rooms and we did not see regular temperature recording of these rooms. We brought this to the attention of the registered manager who put plans in place to ensure these were completed.

Where medicines had been prescribed on an 'as and when' basis the nurse administering medicines asked people whether they wanted any medicine and their wishes were respected. Medicines administered on an 'as and when' basis are known as PRN medicines. People who are unable to communicate their wishes should have a PRN protocol in place so staff know when to administer these medicines. We found in some instances the PRN protocols were not detailed enough to support staff to make this decision. For example, a PRN protocol said to administer a laxative when constipated, however it did not record how to tell when someone was constipated or advise to check their bowel movements. We asked a nurse on duty how they would know whether to administer this medicine and they told us they knew to look at the person's expression. This showed staff were knowledgeable about the person, but this had not been documented. We discussed this with the registered manager and the associate practitioner. The associate practitioner told us they were aware more detail was required in PRN protocols and had already started to review these for each person living at the home. We looked at some of the reviewed PRN protocol records and found they recorded information to support staff to recognise when someone would need their PRN medicine administering.

One person had been prescribed a transdermal patch to alleviate pain. We found this had been administered correctly, however this had not been recorded on a 'body map' so staff were aware of how it had been placed in the event this came off or needed re-applying. This was brought to the attention of the nurse who immediately arranged for a body map to be completed.

The service had an infection control policy; this gave staff guidance on preventing, detecting and controlling the spread of infection. This included the use of personal protective equipment (PPE) including disposable gloves and aprons. Staff confirmed they received regular training in infection control to ensure they knew the correct processes to follow. The cleaning schedule was up-to-date and domestic staff could describe how to prevent and control the spread of infection.

We saw up to date records relating to safety checks of the premises, for example in relation to operation of equipment, gas safety, electrical wiring, water storage and fire alarm testing.

Accidents and incidents were recorded and were logged on a monthly report which was submitted to the registered provider. Analysis of accidents and incidents was also completed; this provided an opportunity for the registered manager to identify patterns or trends, enabling changes to be made to people's care and support to reduce future risk of injury. The registered manager used these to improve the service and shared with staff during team meetings to support learning.

Good

Is the service effective?

Our findings

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. The home had recently reviewed all mental capacity assessments and decisions taken in people's best interests to ensure they were person-specific and valid. One person's care plan showed they had consented to the use of bed rails because it was their personal preference and a mental capacity assessment showed they had the capacity to understand the risks and choose this option.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). 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.

The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. DoLS applications in the home were tracked by the registered manager who had a robust system in place to monitor these. A person with an authorised DoLS had a condition attached that said the home was to ensure this person had access to, and was supported by, local ethnic minority groups. This person's daily activities record showed these details.

The registered manager was aware the home should hold appropriate documentation to protect people who did not have capacity or who may lose capacity in the future. The registered manager had written to all relatives involved in people's care to check whether any of the people they supported had a Lasting Power of Attorney [LPA] in place.

Some people's advanced care wishes, such as those recording whether they wished to be resuscitated in the event of a medical emergency, did not show the home's address. The registered manager was aware about this and was in contact with people's GPs to ensure these were up to date.

The training matrix showed staff had all received mandatory training. Staff confirmed they received regular training to keep them up-to-date. The competency of staff administering medicines was checked on an annual basis. We asked a relative what they thought of staff's skills, one relative replied, "Some are better skilled than others." The registered manager explained how they had plans in place to develop staff 'champions' in areas where staff had an interest, such as dementia or nutrition, which would enhance and encourage staff skills. The service had also organised specialist training for staff to support people's individual needs, such as how to support people who had a percutaneous endoscopic gastrostomy (PEG). The service had plans to introduce competency checks for staff who had received additional training.

New staff with no previous experience in the caring profession completed the Care Certificate. The Care

Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff described the induction process telling us they completed all their mandatory training and then shadowed an experience staff member for two weeks before they started working independently.

Staff had not received regular supervisions or appraisals; the registered manager had commenced these in June 2018 when they joined the home. Fifty per cent of staff had received a supervision in the last 12 months. The registered manager had planned for senior staff to complete all staff supervisions by the end of the year and complete all staff appraisals in the next quarter.

People were able to choose what to eat for each meal; alternatives were available if they changed their mind. A person told us, "They [staff] come round with the menu, two choices, and if you don't like you can have something else. For example, today I asked for a salad for tea."

The cook was knowledgeable about people and told us, "I went round last week and spoke with [people], they said they wanted a mixed grill." Plans were in place to provide this option in the future. Each person's care records had a diet notification sheet indicating their preferences, likes and dislikes. There was a whiteboard in the kitchen which contained up-to-date details of these dietary requirements and allergies. The cook also described their contingency arrangements in the event of an emergency, such as a power cut, to ensure people continued to receive meals.

Staff encouraged people to chat during lunch and it became a lively social occasion. People were encouraged to eat and supported by staff where they needed assistance to do so. Staff quickly identified where one person did not want their choice of meal and made arrangements to get an alternative which the person enjoyed. Drinks were freely available during meals and there was a well-stocked snack station in each dining areas containing tins of soup, crisps, cereals, fruit and biscuits.

One person who had been assessed as being at high risk of malnutrition did not have regular and detailed recording of the food and fluid they had consumed, and their fluid intake was not always totalled. However, we saw monthly weights for each person were monitored and recorded, which showed the service was monitoring the risk to malnutrition. Where there were concerns about people's weight a referral had been made to a dietician or GP.

Staff received up-to-date information to ensure people were supported appropriately and were clear about their duties and the responsible people on each shift. At the start of each shift a handover took place and all staff attended. Handover sheets were detailed and contained a snapshot of information about each person as well as information about the care and support they had received during the shift. These also contained details about the staff working on each shift, staff break allocations, and who the fire marshal and first aiders were. A staff member said, "[At handover] we check paperwork as well." Another staff member said, "We read people's care plans in their rooms…I find the handover at the start of the shift useful. Definitely all staff helping out."

People's records detailed where advice had been sought from health professionals or where the staff had requested visits. For example, care records showed visits by a diabetic nurse to one person. A relative told us, "If [person's name] is not well, they [staff] know and they send [them] to hospital." Another relative said, "The nurse on duty always makes all the arrangements" and another told us, "[Person's name] health has improved." A staff member said, "We know people well. We check when people are poorly and have discussions with other services."

Each person's bedroom was individually decorated, many with personal ornaments, furniture and family

photographs. Bedroom doors recorded the name of the person who lived there and displayed a picture or photograph relevant to them. This can help people to identify their own room. Communal toilet and bathroom doors were easily recognisable with signs and pictures to indicate the purpose of the room.

The home had recently undertaken a programme of refurbishment which was not yet finished. Some of the refurbishments in the first phase related to ensure the premises were safe, such as improving the clinical room. Some people had chosen the colours for their rooms and people had been shown paint, carpet and wall-paper swatches so they were involved in the re-decoration of communal areas.

Good

Is the service caring?

Our findings

Relatives comments when asked about whether staff were caring included, "They (staff) seem to know everybody's name," "[Staff] are friendly with [person's name], they talk to them," "[Staff are] always very co-operative, very helpful, very courteous…They always ask if there's anything they can do for [person's name]" and "Very impressed with the care at Linson Court."

The registered manager told us people's equality and diversity needs were considered during the pre-admission assessment and described how they would ensure these were met. For example, the registered manager was careful not to make assumptions about people's sexuality based on their marital status. Some of the people living at the home had different religious and cultural needs and the home had accommodated these by using staff with similar backgrounds and by involving community groups. The home held a multi-denominational service each month. The registered manager showed good understanding of the need to balance each person's individual cultural needs across the home in regard to other people living at the home.

We observed staff treating people with dignity. For example, during lunch one person looked like they were sleeping, staff gently touched their hand and asked if the person wanted anything to eat or to go to their room, the person didn't want to move so staff spent time patiently encouraging them to eat. On another occasion a staff member administering medicines said, "Oh they're sleeping, I won't wake them up, I'll come back later." A person told us, "Yes, very respected, they knock on the door."

We saw examples throughout the day where staff encouraged people to make their own choices. Saying, for example, "Do you want to stay in your chair or go to a comfy chair?" "Have you had a drink this morning? What would you like?" and "How is that? I've got your favourite," and a person replied, "I like it!"

We observed a person saying, "I do not want [name of medicine] but can you wash my eyes, please?" and the staff member responded with "Yes, of course, [name of person]." A relative told us, "They ask [name of person] and it is [their] choice. They can't do it without their permission."

People's independence was encouraged and supported by staff. A staff member saw a person would better be able to eat with a different spoon and said, "Let me get you a little spoon to eat that."

Records were stored securely so people's confidentiality was respected.

Good

Is the service responsive?

Our findings

Staff confirmed they knew people and their individual needs well. A staff member said, "We know [people] well and [people] know us all, we're like a big family." Staff knew people's life histories well and engaged them in talking about them during lunch.

The registered manager told us they had identified people's care and support needs were not appropriately recorded using an electronic system (NOURISH) because this had not been fully implemented. In July this year the registered manager made the decision to stop using the system and review each person's care and support needs. This would ensure these were accurately recorded using a paper-system before moving to the electronic system. A plan had been produced and senior staff in the home had completed 80% of all the reviews, with the remaining 20% planned to be completed before the end of the year. Staff would be re-trained on the electronic system before people's records were migrated to the electronic system.

Prior to people moving to the home people's physical, emotional and spiritual needs were captured during a pre-assessment process. Records showed these were used to inform people's person-centred care plans, and in those care plans which had recently been reviewed these were detailed and had involved people and their relatives. One person's records showed they had been involved in their care plan and this contained specific information about that person, including their likes and dislikes and their ambitions. The registered manager told us they had introduced a cost of care system during the pre-assessment process to ensure the home had the ability to meet people's needs before they moved to the home.

Care plans provided detailed information about how people should be supported to maintain their independence. For example, one person's care plan described how they had access to a mobility scooter and used this to go out on their own. Daily records were relevant to the care and support needs recorded in people's care plans.

People's communication needs were assessed and information provided to people in a suitable format. We checked what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

People's communication needs were recorded in care plans and included details of how staff should communicate with people. For example, one person did not have English as their first language. Staff had produced flash cards with words and phrases in the person's language so they could speak with the person and the person could point at phrases to show what they wanted to say. There were also staff members who could converse with this person and the person received frequent visits from community groups and family to provide meaningful communication.

Information about an advocacy service was available throughout the home. The registered manager told us no one living at the home at the time of our inspection used an advocate.

People's social needs were supported. Group activities within the home were varied and planned, however many people living at the home were cared for in bed and we did not see a record of person-specific activities for these people. The home had two full-time activity co-ordinator posts however due to maternity and other leave these were not fully operational during our inspection and this impacted on the range of activities available. We asked one person about the activities they enjoyed in the home and was told, "There is a girl that comes with the dominoes and we play." We asked another person whether they took part in any activities and we were told, "No, I just listen to the radio." Another person said, "Not a lot, it's the only thing that lets them down in here…I do some gardening."

During lunch time we observed four people chatting and joking about who wins at games such as dominoes and snakes and ladders; they confirmed they played regularly. People also told us about outings they had enjoyed such as a Halloween party, going to the park, and visiting a garden centre. They also described how much they had enjoyed visits by local school children who had come to play the banjo and they had a sing-a-long.

The home had introduced a weekly afternoon tea and we observed cakes displayed on a tiered-stand and people enjoying choosing from this.

The complaints policy was displayed in the home and also in the service user guide. We saw four concerns had been received since our last inspection. All four had been investigated and responded to appropriately by the registered manager. A person told us, "I had a complaint because of my medications, [staff name] couldn't explain so we went to see [name of manager]."

Care plans showed people were asked about their end of life wishes and where they had expressed these wishes these had been recorded in an advanced care plan. Staff described how they discussed people's needs with health professionals and relatives and worked closely with the local hospice. The local hospice had recently visited the home to discuss how to build trust and relationships with people and their relatives. Staff explained the importance of keeping relatives involved and explaining each stage in people's care.

Good

Is the service well-led?

Our findings

We asked staff about how the home was managed and comments included, "Since [name of manager] has been here they have been very approachable…the home has been so much more pleasant. If you ask for something you get it," "Since [name of manager] a lot of information, team meetings, now briefings," "Oh, yes, [name of registered manager] is really comfortable to talk to about things and [they] get on with it straight away," "The manager seems OK…trying to help the home, really supportive deputy manager," "There's been lots of changes for the better, it is getting better, and the deputy manager is really approachable," and "It's better than anywhere I've ever worked before. It's about what people want."

Relatives confirmed they felt able to approach the registered manager. One relative told us, "I would speak with a senior or the manager." Another relative said, "We know the manager very well."

The registered manager described the support they received from the registered provider. They told us, "[Registered provider] absolutely listens, they want things to move forward, they are as passionate as we are. The owner rings on a daily basis and is very supportive…very responsive."

There is a requirement for the registered provider to display ratings of their most recent inspection. A poster displaying the ratings from the previous inspection was on display within the home and the rating, along with a link to the CQC report, was also available on the registered provider's website.

The registered provider had a range of policies to provide a clear framework for good quality care and support; these were dated and included regular times for review. Reviewing policies helps to ensure they are up to date and reflective of current legislation and good practice.

Regular monthly audits had been conducted to ensure care and support was monitored and managers could account for the actions of their staff. These covered a range of aspects concerned with the management and the safety of people living at the home and included quality audits of care plans, medicine inspections, nutrition recording inspections, environment inspections, and 'resident experience' inspections. Where issues had been identified there was an action plan which showed who had responsibility for rectifying the issue and by when. All actions from recent audits had been completed. Whilst we found some areas of concern in people's care and support plans during our inspection these were in care plans which had not yet been reviewed, as part of the registered manager's programme of wholescale reviews. From the newly reviewed care plans we looked at we were satisfied these documented care and support needs accurately.
The provider undertook a bi-monthly inspection visit. The last one had taken place in June 2018 and had identified improvements needed to staff notices and memos, agency staff usage, annual appraisals, staff meetings, and 'residents and relatives' meetings. Improvement had been made in each area apart from staff appraisals, where we saw plans were in place to address this.

It was recognised that whilst we found some concerns relating to the safety of people living at the home the provider had already identified these issues and had made plans to address them.

Staff were involved in how the home was run and confirmed meetings were held on a regular basis. This helps staff understand their roles and responsibilities. A staff member said, "We have 'flash' meetings and also 'big' staff meetings." Another staff member said, "We have a lot of meetings, and, yes, we're asked for our views." Staff attended joint meetings with a local 'sister' home to share best practice and skills.

People and their relatives had a say in how the home was run. A relative said, "When they were doing the refurbishment…we were kept informed." A relative said, "We've always been part of any activities…[such as] listening to children from local schools." 'Residents and relatives' meetings took place regularly. Minutes showed actions from these were completed and confirmed at the next meeting.

People, relatives and staff surveys had not taken place so far this year. A staff survey had been sent out in October 2018. The registered manager provided us with copies of the previous year's surveys and the analysis from these.

The home had developed links with a local school and pupils had visited the home to sing to people. The registered manager described how they wanted people in the home to reflect the local community and had made links with lots of different community groups who visited the home.