Whitegates Retirement Home Ltd

Park View Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We inspected this service on the 28 January 2015 and this inspection was unannounced. Park View Care Home is a purpose built care home with nursing. It provides care for up to 61 older people who may be elderly and or have a physical disability. Some people are living with dementia. There were 53 people living in the service when we inspected.

There was a registered manager in post. 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 were positive about the care they received. The atmosphere in the service was warm and welcoming.

People told us staff listened to them and acted on what they said. People were supported and encouraged to attend appointments with other healthcare professionals to maintain their health and well-being.

Summary of findings

Staff knew how to recognise and respond to abuse correctly. People were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Any risks associated with people's care needs were assessed and plans were in place to minimise the risk as far as possible to keep people safe. Appropriate arrangements were in place to provide people with their medication safely.

People were supported by sufficient numbers of staff with the knowledge and skills to meet their needs. Staff respected people's privacy and dignity and interacted with people in a caring and respectful manner.

Staff were knowledgeable about people's choices, views and preferences and acted on what they said. However this information was not always reflected in people's care records to ensure best practice was followed.

People voiced their opinions and had their care needs provided for in the way they wanted. Where they lacked capacity, appropriate actions had been taken to ensure decisions were made in the person's best interests.

The majority of people were encouraged and supported with their hobbies and interests and participated in a variety of personalised meaningful activities. However people who were nursed in bed had limited interactions and meaningful engagement and were at risk of isolation.

People were supported to be able to eat and drink sufficient amounts to meet their needs. They told us they enjoyed the food and were provided with a variety of meals. People were encouraged to be as independent as possible, but where additional support was needed this was provided in a caring and respectful manner.

People knew how to make a complaint and said that any concerns were acted on promptly and appropriately.

The management team planned, assessed and monitored the quality of care consistently. Systems were in place that encouraged feedback from people who used the service, relatives, and visiting professionals and this was used to make continual improvements to the service.

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?
The service was safe.

Staff understood their responsibilities to protect people from harm and report any concerns about people's welfare.

There were enough staff to meet people's needs.

People were provided with their medicines when they needed them and in a safe manner.

Good

Is the service effective?
The service was effective.

Staff were supported to meet the needs of the people who used the service. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented.

People were supported to maintain good health and had access to ongoing healthcare support.

People told us they had plenty to eat and drink. People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

Good

Is the service caring?
The service was caring.

People had their privacy and dignity respected and were supported to maintain their independence.

People and their relatives were involved in making decisions about their care and these were respected.

Staff were compassionate, attentive and respectful in their interactions with people.

Good

Is the service responsive?
The service was not always responsive.

People's choices, views and preferences were respected and taken into account when staff provided care and support. However they were not always reflected in their care records.

Not everyone had their social needs met. People who were nursed in bed had limited interactions and meaningful engagement and were at risk of isolation.

Requires improvement

Summary of findings

People knew how to complain and share their experiences. There was a complaints system in place to show that concerns were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well-led.

There was an open and transparent culture at the service. People told us the management team were approachable and a visible presence in the service.

Staff told us they were encouraged and supported by the manager and were clear on their roles and responsibilities.

People's feedback was valued and acted on. Systems were in place to monitor the quality and safety of the service provided and used to plan on-going improvements.

Park View Care Home

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 unannounced inspection took place 28 January 2015. The inspection team consisted of an inspector and a specialist advisor who had knowledge and experience in nursing and dementia care.

We looked at information we held about the service, including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with eleven people who used the service, five relatives and two visitors. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who may not be able to verbally share their views of the service with us. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with a member of the provider's senior management team, the registered manager and eleven members of staff, including care staff, catering, domestic, admin and activities staff. We reviewed feedback received about the service from five health and social care professionals. We also looked at records relating to the management of the service, staff recruitment and training files and systems in place for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said about the staff, "I like and trust them and feel very safe here." Another person said, "I am completely safe and at ease here. All my things are here, kept safe and secure like me." Relatives told us they believed people were cared for safely.

Staff received training around the importance of protecting people and keeping them safe from potential harm. They explained their training was regularly updated and they were encouraged to report any concerns. One staff member said, "The manager and team leaders expect and encourage us to talk about any issues and if we find concerns we are to report them straight away. People's safety and wellbeing is important." Staff knew how to recognise and report any suspicions of abuse within their own organisation. However not all staff were aware of how to report concerns externally, for example through the local authority's safeguarding referral process.

Staff understanding of the provider's whistleblowing processes for reporting bad practice also varied. One staff member told us about their experience of raising concerns and how it was handled they said, "I have raised things before when I wasn't happy with things or sure were right. The manager dealt with it straight away. If they hadn't I would have gone higher. The owners are often here and you can talk to them. Or there are numbers in the office I can call if I need to act further." We spoke to the manager about the inconsistent approach in staff understanding. They advised of the actions they would take to address this which included further guidance and support to staff through internal communications, additional training and information made visible in the service for staff to access. We were assured by the measures the manager proposed that people would be protected from abuse and avoidable harm.

The provider worked with the local authority to address safeguard concerns and took steps to address shortfalls where identified. Systems were in place to identify, report and act on concerns about people. The management team notified us of events of suspected or potential abuse and informed us of actions taken to address these issues. This included raising safeguarding alerts to the local authority who were responsible for investigating safeguarding concerns.

Systems were in place to protect people and minimise risk in their daily lives. For example, low profile beds, sensor mats and bed rails were used appropriately for people identified at risk of falls. Risk assessments identified how and when these should be used and provided guidance to staff in how to support people safely.

Equipment including the passenger lifts and hoists had been serviced, was fit for purpose and safe to use. The environment was free from obstacles which could cause a risk to people as they moved around the service. Records showed that fire safety checks and fire drills were regularly undertaken to reduce the risks to people if there was fire. Guidance was available in the service to tell people, visitors and staff of the evacuation process in the event of a fire.

People told us that there were enough staff available to meet their needs and were confident someone would come when called. One person said, "The staff are quick to come. They know I could fall and don't take any chances with me. They keep me safe from harm. I have all the kit and caboodle (specialist equipment) to keep me safe and if I press my call bell they come straight away." Relatives and visitors told us they came at different times to the service and said there were sufficient numbers of staff to meet people's needs. One visitor said, "I noticed there is more staff around during the busier times, during meals and if an emergency arises then the activities staff will pitch in."

The manager advised us that the staffing levels were flexible and could be increased should people's dependency levels rise. Our discussions with staff and people who used the service, the staff rota and our observations confirmed the staffing level arrangements in place.

People had their health and welfare needs met by staff who had been recruited safely. Staff told us the provider had interviewed them and carried out the relevant checks before they started working at the service. Records we looked at confirmed this.

People told us they received their medicines as prescribed and intended. One person said, "I always get my tablets on time. (Staff) wait for me as it takes me awhile to take my pills. But I am never rushed. They bring me a drink and explain what each tablet is for as I forget." Another two people we spoke with confirmed they received their medications on time and if they had any pain would speak to a nurse and their tablets would be brought.

Good

Is the service safe?

The provider had suitable arrangements in place for the management of medicines. Medicines were stored safely for the protection of people who used the service. Records showed when medicines were received into the service, when they were given to people and when they were disposed of. We observed a member of staff appropriately administering medicines to people.

PRN directions were clear and provided comprehensive information to staff including non-verbal signs a person may display if PRN analgesia was needed, for example facial grimacing. However, two people prescribed a sedative medication on a PRN basis had received the maximum daily doses every day for the past two weeks. Their daily log and medication records did not explain the need for these doses and when their medication was to be reviewed and suitable ongoing medications prescribed. We followed this up with the manager who confirmed medication referrals including reviews would be arranged. They advised us that to ensure people received their PRN medication safely PRN processes would be reviewed with further referrals made if required.

Good

Is the service effective?

Our findings

People told us that care staff had the skills to meet their needs. One person said, "They [staff] are well trained and know what they are doing. I have never had any problems. Staff are more than competent. And helpful and friendly." One person's relative commented that staff were, "Approachable, accommodating, very well trained and extremely caring."

Staff told us that they were provided with core training, refresher updates and specific training to meet people's requirements and preferences effectively. Care staff on the specialist dementia floor told us they were confident they could meet the needs of people living with dementia. They told us their dementia awareness training had described the effects dementia had on the brain, how it affected people and had helped them to understand the impact it had on the person and their families. One member of staff said, "It [Dementia] affects people differently; it can change people who were once outgoing to becoming withdrawn and vice versa. People can get frustrated when they can't remember or do things they used to be able to and families can struggle with the changes they see happening and not know how to help. We [staff] have to adapt and provide individual care for each person."

Systems were in place to ensure that staff received training, achieved qualifications in care and were regularly supervised and supported to improve their practice. This provided staff with the knowledge and skills to understand and meet the needs of the people they supported and cared for. Staff told us they felt supported and were given the information they needed to deliver care and support to an appropriate standard. People benefited from staff who understood how to meet their needs.

Staff told us that people's care records were regularly reviewed and updated to inform and guide them about changes to people's care. Individual assessments covered identified risks such as nutrition, moving and handling and pressure sores, with clear instructions for staff on how to meet people's needs safely and effectively. For example, people nursed in bed were on suitable airflow mattresses with repositioning charts used to ensure people were comfortable and to reduce the risk of pressure sores.

Staff supported people to mobilise using equipment to maintain their independence effectively and appropriately.

Staff were knowledgeable about people's individual needs, including those living with dementia, and how they were met. Staff on the specialist dementia floor communicated effectively with people; were at ease making conversation with people. They used reassuring touch appropriately and maintained eye contact with people when they communicated. However, staff on another floor were not so comfortable communicating with people when tasks were not involved. For example, during the lunch time meal conversation was free flowing with staff engaged and interacting well with people. After the meal conversation became limited to staff asking people if they wanted further refreshments or wished to return to their bedroom. People became withdrawn and subdued. We raised this with the manager who advised that further person centred care training including effective communication was being rolled out to all staff having been successfully implemented on the dementia floor. Records seen confirmed this.

We saw that staff acted in accordance with people's wishes. For example, one person told a member of staff when they came to assist them to lunch in the dining room they had changed their mind and wanted to eat in their bedroom. The member of staff agreed to bring their lunch to their room.

People told us how their individual needs were met and that staff asked for their consent before any care or treatment was provided. One person said, "They [staff] all check first if you need help before they start. Sometimes I say I am not ready and fancy a lie in and don't want to get up yet and that's fine. Some days I need more help than others but they always ask first and I tell them what's what."

Staff understood Deprivation of Liberty Safeguards (DoLS) legislation and referrals to the local authority in accordance with new guidance were made to ensure that any restrictions on people, for their safety, were lawful. Staff also understood the Mental Capacity Act 2005 (MCA) and were able to speak about their responsibilities relating to this. Records seen confirmed that staff had received this training and had discussed it in staff meetings.

Care plans identified people's capacity to make decisions. Where people did not have the capacity to consent to care and treatment an assessment had been carried out. People's relatives, health and social care professionals and staff had been involved in making decisions in the best interests of the person and this was recorded in their care plans. For example, decisions associated with covert

Good

Is the service effective?

administration of medication and end of life care arrangements were documented. Where DoLS referrals had been made, these were kept under review to make sure that they were relevant and up to date. However in two of the seven care records seen it was not clear how capacity had been assessed and how decisions had been reached. The manager advised us that they would review these records and address the inconsistencies.

People were complimentary about the food. They told us they had plenty to eat and drink, their personal preferences were taken into account and there was choice of options at meal times. One person said, "The food here is tasty and fresh and always cooked properly." Throughout the day people were provided with an availability of snacks, refreshments and fruit. Staff made sure people who required support and assistance to eat their meal or to have a drink, were helped sensitively and respectfully.

Arrangements were in place that supported people to eat and drink sufficiently and to maintain a balanced diet. This included enough staff to support those who needed assistance, and be aware of how to meet people's individual dietary needs. For example, where people were identified at risk of choking staff used prescribed thickeners for liquids to support them to drink liquids safely.

People said that their health needs were met and had access to healthcare services and ongoing support where required. One person said that there were regular visits from a nurse and that staff, "Will quickly call a doctor if you need one." One person's relative told us that their relative had regular visits from the GP and other professionals when needed and the staff were quick to act they said, " The staff are fantastic and keep on top of all the appointments and are very quick to act if they spot a change in circumstance."

Records showed routine observations such as weight monitoring were effectively used to identify the need for specialist input. Documentation showed that staff worked closely with Speech and Language Therapists and dieticians in relation to swallowing needs and people identified underweight on admission to the service.

A visiting healthcare professional stated that nursing staff made appropriate referrals to the surgery and were able to accurately report signs and symptoms to enable effective telephone triage. They confirmed that prescribed treatment plans were followed by the staff.

Good

Is the service caring?

Our findings

People told us that the staff were caring, kind and treated them with respect. One person said. “The staff are always cheerful and kind and very patient with me.” Another person said, “I think they are absolutely lovely girls, they are the nicest part of being here.” Relatives described the staff as welcoming, knowledgeable, approachable and helpful.”

People and their relatives told us that the staff wore different uniforms which helped them to know their individual roles. One person told us, “My favourite [staff member] is not working today and wears blue,” referring to one of the care staff.

People told us the staff respected their choices, encouraged them to maintain their independence and knew their preferences for how they liked things done. Staff took time to explain different options to people around daily living and supported them to make decisions such as what they wanted to eat and drink, where they wanted to spend their time and whether or not to join in group activities. Staff listened and acted on what they said. Two relatives told us they were kept ‘very well informed’ about the daily routines and wellbeing of people.

We observed positive interactions between staff and people on the specialist dementia floor. Communication with people with dementia was adapted to meet their needs for example; staff used short clear sentences to give information and allowed time for people to respond. Conversation was meaningful and relevant to people. Staff demonstrated their knowledge and understanding of people and their interests by engaging with them in conversation and activities they enjoyed. Where people did not communicate verbally we saw that staff observed body language and facial expressions to understand people’s needs and responded appropriately.

Staff on the specialist dementia floor demonstrated an awareness of people’s individual preferences and interests and supported people to develop friendships with one another. Conversations between people were encouraged and facilitated by staff. For example, during the lunch time meal care staff prompted a person to join in a conversation with other people, helping them to express themselves by repeating what had been said so everyone could hear.

However not all staff appeared comfortable in making conversation with people or including them in social interactions that added to their wellbeing. Whilst the majority of staff regularly talked with people and monitored them closely, not all staff appeared at ease in their communications when tasks were not involved. The majority of interactions on one floor were task focused. For example, we saw two people sitting in the lounge asked repeatedly during a 30 minute period by three different members of staff if they would like a drink or assistance back to their bedroom. Apart from establishing people were not thirsty or wanted to move no other conversation or engagement took place.

We spoke to the manager about the inconsistent approach to care by a small minority of staff. They advised us of their plans to address this shortfall. This included providing additional training in person centred care to all staff. The training included enhanced communication skills for staff and developing their understanding of meeting the needs of people with dementia. The training had been delivered to staff on the middle floor and was currently being delivered to the remaining staff teams. The manager explained they were an active and visible presence in the service; working alongside their staff delivering care to people and supporting staff. Due to personnel changes and concerns raised about meeting people’s needs they had prioritised their time working on the middle floor to address shortfalls identified by the local authority. They advised us they were working with the local authority and other professionals where required to deliver a high quality of care. They confirmed they had appointed a team leader for the middle floor with a dementia nursing background which would free them up to oversee the continual improvements to ensure the quality and safety of the service.

People’s privacy and dignity was respected and promoted when staff attended to their care needs. For example, when assisting a person to walk from one area to another staff encouraged the person to do as much as possible whilst providing a reassuring presence. On another occasion a member of staff assisting a person into a wheelchair and demonstrated due regard for the person’s dignity by ensuring their clothing was adjusted and they were comfortable and settled before mobilising.

However the language used by staff and within care records did not always value people and maintain their dignity. For example, some staff described people who were nursed in bed as bed–bound which implies the

Good

Is the service caring?

person is restrained. In three people's daily log records an individual was described as 'agitated in their chair'. The records did not show how staff had tried to find the cause of the distress or actions taken to ease the symptoms; determine the cause of the behaviour. The manager explained that the existing care plans had limited space for staff to write information and were being replaced with a new format that would enable staff to reflect the actions taken to reduce anxiety and alleviate a person's distress. They added that training and support would be delivered to staff to document the person centred care they provided with emphasis on ensuring people's privacy, dignity and human rights were respected.

Requires improvement

Is the service responsive?

Our findings

People told us their care needs were met in a timely manner and that staff were available to support them when they needed assistance. One person told us, "The staff are kind and attentive. If I press my call button they come very quickly." Another person said about using the call button for assistance, "Only used it a few times, in say an emergency and they [staff] came quickly. We observed that staff were attentive to people, checking on them in the communal areas and bedrooms. Call bells were answered promptly and requests for help given immediately.

People told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. One person said, "The staff here in general are very good, approachable and quick to act if I need anything. Never been a problem if I want help, need something or want to go somewhere."

Many people chose to have their lunch time meal in their bedroom. In response to this meal time arrangements were organised to support this choice, including staggering meal times and ensuring there were sufficient numbers of staff to provide people with their food in a timely manner and assistance if needed. We saw that one person had not touched their food. A member of staff checked with the person and found they had not been given their false teeth and their food had not been cut up so they couldn't manage. We saw that the member of staff attended to these needs and the person ate their meal independently. The member of staff advised us they would mention this during handover to remind staff of how to meet this person's needs.

Staff talked to us about people's specific needs such as their individual likes and dislikes and demonstrated an understanding about meeting people's diverse needs, such as those living with dementia. For example, how people communicated their needs, mobilised and their spiritual needs.

Although staff demonstrated an understanding of people's needs this information was not always reflected in people's care records. Whilst care plans and risk assessments were reviewed and updated to reflect people's changing needs, their preferences were not always reflected. Care records provided inconsistent information about individual choices, aspirations and wishes. People's daily logs were not always personalised and focused on the tasks undertaken. They did not give an indication on the overall mood and wellbeing of the person including any changes in their behaviour or appearance. Information about people's history, such as their hobbies and interests was limited and it was not clear how activities were planned for people which would interest and stimulate them. Improvements were needed to ensure people received personalised care responsive to their needs and that their views were listened to and acted on.

We found inconsistencies in the monitoring and recording of people who remained in their bedrooms and required all care and support from staff. People were at risk because care records and checks carried out by staff on people's wellbeing were not correctly completed and recorded. For example, one person's chart showed planned repositioning every two - three hours but the record showed several gaps in excess of four hours. The person was comfortable and had suitable protective padding to reduce the risk of pressure sores and was nursed on an air flow mattress. The care arrangements were responsive to their needs but the records had not been reviewed to reflect their improving health and need for less frequent repositioning

People told us that there were social events that they could participate in, both individual and group activities. One person said, "Always something going on downstairs [ground floor]. I sometimes get involved when I am waiting to get my hair done in the salon. [On site hairdressing facility]." Another person said about the activities staff, "I like [staff member] very much, [staff member] has a lovely way about them and gets everyone involved. Seems to come naturally for them; they are a people person."

However people nursed in bed or who chose to remain in their bedrooms were at risk of social isolation through the lack of meaningful stimulation and engagement. Our observations and discussions with people, their relatives and staff showed that there were not enough relevant activities for people to meet their individual needs. For example, activity logs for people nursed in bed or who chose to remain their bedrooms stated 'listened to music' as the only social or cognitive activity undertaken for several days. It was not clear what other meaningful activity took place to add to their quality of life or wellbeing. One relative told us, "I worry that [person] is bored and there is not enough to do. I know that some of the staff will sit and

Requires improvement

Is the service responsive?

chat or read to [person] when I am not here as I have seen this but it is only a few that take the time and do this. Some [staff] are better than others in caring for people who need more care."

People and relative's feedback was valued and acted on. For example, a request for the music player on the ground floor to be on all the time had been actioned as had a request for 'proper' tablecloths on the dementia floor.

People told us they knew how to make a complaint but had not done so as the staff and management team acted quickly when they raised any issues. For example, one person told us how the manager had taken their comments seriously, met with them to talk it through and acted immediately to resolve the problem. The matter was settled and they were satisfied with the way their concern had been handled.

The provider's complaints policy and procedure was made freely available in the service and contained details of relevant external agencies and the contact details for advocacy services to support people if required. Staff were able to explain the importance of listening to people's concerns and complaints and described how they would support people in raising issues. We saw that where concerns had been raised the manager shared any learning and made changes to limit any reoccurrence whether for the person who raised the concern or others.

Good

Is the service well-led?

Our findings

People told us they felt respected and included because the manager and staff were approachable, helpful and valued their opinions. People and relatives told us they liked that they were able to identify the different groups of staff members by their uniforms. One person said, "You know who is who by the colour of their tunic and what their job is. The carers and nurses wear different colours. If you need to speak to someone in charge about something it's clear who to go to. Plus the manager is around as well but I haven't had to involve them as if there is a problem the nurses' deal with things right enough." A relative said that the manager was, "Very helpful," and if their relative needed anything they were, "Contacted straight away. I find the communication from them is great."

Relatives said the manager and provider were a visible presence, accessible to them and they had confidence in their running of the service. They said that they attended meetings which they considered worthwhile because the management team had acted on the feedback given which improved things. One person said, "There was an issue with bath times and getting [person] up too early. We raised this and it was dealt with immediately; don't think that there has been any further problems. Certainly none that I am aware of."

The atmosphere in the service was warm, friendly and welcoming. One person told us how comfortable they had felt coming into the service they said, "You can come anytime and treat it like your own home." People, their relatives and staff were at ease with senior team and manager. It was clear from our observations and discussions that there was an open and supportive culture in the service.

Staff told us that the manager and the provider were approachable, supportive and listened to what they said. Staff understood their roles and responsibilities in providing good quality and safe care to people.

The manager told us that they felt supported in their role and that they had regular support from the provider both informally in their regular visits to the service and formally in their supervision and appraisal meetings.

People, relatives and visitors told us they had expressed their views about the service through regular meetings and through individual reviews of their care. A satisfaction survey also provided people with an opportunity to comment on the way the service was run. We saw that action plans to address issues raised were either completed or in progress. Meeting minutes showed the open communication between people, relatives, staff and management. People were encouraged to feedback about the quality of the service and to share ideas and suggestions for improvements. For example, people had contributed towards decisions that affected their daily life such as menu choices and variety of activities offered. This showed us that people's views and experiences were taken into account and acted on.

People received safe quality care as staff understood how to report accidents, incidents and any safeguarding concerns. Staff followed the provider's policy and written procedures and liaised with relevant professionals where required. The manager assured us that they would address the inconsistencies we found in staff understanding and awareness of the provider's whistleblowing policy to ensure all staff knew how to report any concerns to managers and agencies outside of the service and organisation. This included additional training, internal communications and making safeguarding information visible and accessible within the service.

Actions were taken to learn from incidents, for example, when accidents had occurred risk assessments were reviewed to reduce the risks from happening again. Incidents were monitored and analysed to check if there were any potential patterns or other considerations (for example medication and or underlying health conditions) which might be a factor. Attention was given to how things could be done differently and improved, including what the impact would be to people. For example, the accident/ incident log showed an episode where a person with dementia had become increasingly aggressive, prompting a referral to secondary mental health services and a new treatment plan. Following these actions the person's symptoms were resolving with no further incidents reported.

A range of audits to assess the quality of the service were regularly carried out. These audits included medication processes and health and safety checks. Environmental risk assessments were in place for the building and these were up to date. Information and identified trends from these audits were analysed by the manager and contributed

Good

Is the service well-led?

towards a programme of improvement. With actions identified to ensure people were protected and safe. For example, trolleys were ordered to assist staff with the transportation of clinical waste.

The provider's quality assurance systems were used to identify shortfalls and to drive continuous improvement. Audits and checks were made in areas such as medication, falls and the safety of the environment. Where shortfalls were identified actions were taken to address them. Records and discussions with the manager showed that incidents, such as falls, complaints and concerns were analysed and monitored. These were used to improve the service and reduce the risks of incidents re-occurring. This helped to make sure that people were safe and protected as far as possible form the risk of harm.